PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D24

PROVIDER –
New England Deaconess Hospital
Boston, Massachusetts

Provider No.: 22-0118

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services

DATES OF HEARING -
February 28, 2007 and
March 1, 2007

Cost Reporting Period Ended –
September 30, 1996

CASE NO.: 99-2786

INDEX

ISSUE:

Whether the Intermediary's disallowance of the Provider's claim for a loss in connection with its October 1, 1996 statutory merger was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

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

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

A provider is entitled to claim as a reimbursable cost the depreciation (i.e., the loss of value over time) of property, plant and equipment used to provide health care to Medicare patients. An asset's depreciable value is initially set at its "historical cost," generally equal to the purchase price. 42 C.F.R. §413.134(b)(1). To determine annual depreciation, the historical cost is then prorated over the asset's estimated useful life in accordance with an acceptable depreciation method. 42 C.F.R. §413.134(a)(3).

The calculated annual depreciation is only an estimate of the asset's declining value. If an asset is ultimately sold by the provider for less than its undepreciated basis calculated under Medicare (equivalent to the "net book value" and equal to the historical cost minus

the depreciation recognized and claimed as allowable costs under the Medicare program, see, 42 C.F.R. §413.134(b)(9)), then a "loss" has occurred, since the sales price was less than the estimated remaining value. In that event, it is assumed that the asset had depreciated more than was originally estimated and, accordingly, the Program provides additional reimbursement to the provider. Conversely, if the asset is sold for more than its undepreciated basis, then a "gain" has occurred, and the Secretary takes back or "recaptures" previously paid reimbursement. 42 C.F.R. §413.134(f)(1).

Where a provider sells several assets for a lump sum sales price, the regulation at 42 C.F.R. §413.134(f)(2)(iv) requires the determination of the gain or loss (depreciation adjustment) for each depreciable asset by allocating the lump sum sales price among all of the assets sold in accordance with the fair market value of each asset as it was used by the provider at the time of sale. An appropriate part of the purchase price is allocated to "all 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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

New England Deaconess Hospital (Provider) was a 385-bed tertiary care surgical teaching hospital located in Boston, Massachusetts. On October 1, 1996, the Provider consummated a statutory merger with Beth Israel Hospital Association (BIHA), at which point the Provider ceased to exist. BIHA, as the surviving legal entity, changed its corporate name to Beth Israel Deaconess Medical Center, Inc. (BIDMC) and continued to participate in the Medicare program under the provider number of BIHA. The Secretary of the Commonwealth of Massachusetts issued a Certificate of Merger certifying to the Provider's statutory merger into BIHA. The provider number of New England Deaconess Hospital was retired in accordance with Regional Office Manual (HCFA Pub. 23-2), §6170. In accordance with the Provider Reimbursement Manual (PRM), Part I (CMS Pub.15-1), §2414.2(A), the Provider filed a terminating cost report.

Simultaneously with the merger of the hospitals, the Provider's parent, Pathway Health Network, Inc. (Pathway) merged, along with Mount Auburn Foundation, Inc. (Mount Auburn), into the Beth Israel Corporation (BIC), the parent and sole member of the Beth Israel Hospital Association. BIC was the surviving legal entity of that statutory merger and changed its name to CareGroup, Inc. (CareGroup). The Secretary of the

Commonwealth of Massachusetts certified the statutory merger of Pathway and Mount Auburn into Beth Israel Corporation. Pathway ceased to exist.

After the merger, the BIDMC Board of Trustees consisted of 40 voting members . In addition, BIDMC had 11 designated non-voting trustees emeritus. Of the 40 voting members, 12 (or 30%) had previously served on the Provider or Pathway boards prior to the merger. Of the 11 trustees emeritus, four had served as trustees emeritus to the Provider, and one had served as an *ex officio* member of the Provider's board.

After the merger, the CareGroup Board of Directors consisted of 29 persons, 10 of whom formerly served as trustees, officers, or directors of the Provider or Pathway. Eight members of the initial twenty-nine person CareGroup board formerly served on the Pathway board. An additional two members of the initial CareGroup board had previously served on the Provider's board. In total, 34.5% of the initial CareGroup board had served previously on either the Provider's board or the Provider's parent board.

On August 31, 1998, the Provider filed an amended cost report claiming a loss of $8,370,165. On September 29, 1998, the Intermediary issued an NPR disallowing the Provider's loss. On March 25, 1999, 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 Deborah K. Gardner, Esquire, and Jeffrey L. Heidt, Esquire, of Ropes & Gray, L.L.P. The Intermediary was represented by Arthur E. Peabody, Jr., Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The parties stipulated that the Provider statutorily merged under state law with BIHA[1] and that prior to and at the time of the transaction, neither the Provider nor Pathway was related to BIHA or BIC.[2]

The Provider contends that the plain language of 42 C.F.R. §413.134(1)(2)(i) establishes that the relatedness inquiry is based solely on the pre-merger relationship of the parties. The evidence showed that CMS interpreted and applied 42 C.F.R. §413.134(1)(2)(i) to focus only on the pre-merger relationship of the parties. Prior Board decisions have likewise interpreted 42 C.F.R. §413.134(1)(2)(i) to require a pre-merger analysis of relatedness. In addition, the administrative guidance does not support the Intermediary's position. CMS' Program Memorandum (PM) A-00-76 issued on October 19, 2000, four years after the transaction, does not provide a basis for a post-merger relatedness determination because it is a substantive change in policy that must go through a process of notice and comment rulemaking. The Intermediary's construction of the regulation undermines its intent and operation. Even if 42 C.F.R. §413.134(1)(2)(i) were interpreted to require a post-merger determination of relatedness, the evidence showed that the

[1] P-128.
[2] 1 Tr. at 36.

parties were not related after the merger. It is undisputed that the Provider did not exist after the merger, and could not "own" any of its assets after the merger or exercise significant control over BIDMC or CareGroup.

The Provider further contends that CMS' conditioning of loss recognition in a statutory merger upon satisfaction of *bona fide* sale criteria, including the test based on what the PM defines as "reasonable consideration," is an invalid interpretation of 42 C.F.R. §413.134(1)(2)(i). The evidence established that the reference to paragraph (f) in 42 C.F.R. §413.134(1)(2)(i) does not impose additional criteria for loss recognition. Instead, it insures necessary adjustments to depreciation costs of terminating providers. The reference to paragraph (f) does not alter a merging provider's entitlement to gain or loss recognition but rather clarifies how to compute gains and losses for different methods of disposing of assets. Reasonable consideration is not a condition of gain or loss recognition under 42 C.F.R. §413.134(1)(2)(i). Until May 2000, CMS had no definition of *bona fide* sale, let alone one that incorporated a reasonable consideration requirement. CMS chose to recognize gains or losses from statutory mergers without a reasonable consideration test.

The Provider argues that by imposing value tests that have no conceptual relevance in merger transactions, the "disparity test" in CMS' PM produces irrational results, spawns regulatory contradictions, and undermines the rule of loss recognition in statutory mergers. The disparity test's reliance on price is misplaced because in a statutory merger, price is not indicative of consideration. The disparity test's concept of fair market value contradicts CMS' regulatory definition of fair market value contained in 42 C.F.R. §413.134(b)(2) and CMS' rejection of an appraisal requirement as a condition for loss recognition. The disparity test contained in the administrative guidance effectively nullifies 42 C.F.R. §413.134 (1)(2)(i). The purchase price in a nonprofit statutory merger represents the actual cost incurred by the surviving provider and must be treated as such in order to avoid unlawful cost-shifting.

For at least twenty years, CMS interpreted 42 C.F.R. §413.134(1)(2)(i) as not requiring that a merger transaction meet the criteria of *bona fide* sale in order for a gain or loss to be recognized. The Provider argues that the Board's prior decisions similarly concluded that a merging provider's entitlement to gain or loss recognition is not conditioned upon satisfaction of *bona fide* sale criteria. Even if a *bona fide* sale requirement applies, the evidence showed that the Provider's merger with BIHA was *bona fide* in that the Provider's merger was an arm's length transaction between willing and well-informed parties, and the Provider received "reasonable consideration." Finally, the Provider argues that Medicare law requires recognition of its loss due to the principles of fairness and equity.

The Intermediary contends that the merger was between related parties as defined in 42 C.F.R. §413.17. The CMS Administrator's decision in Iowa Luthern Hospital[3] and

[3] Iowa Luthern 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.

UPMC - St. Margaret Hospital[4] overturning these PRRB decisions support the application of the related organization principle to this case. Further, the merger failed to meet the *bona fide* sale criteria outlined in PM A-00-76. An appraisal of assets was not conducted until ten years after the merger, and the validity of that appraisal is suspect. From the testimony it is unclear whether the appraiser had all the necessary contemporaneous documentation needed for an accurate appraisal. Further, since no cash changed hands between the parties, there was only an assumption of assets and liabilities. Finally, there was a 22% variance between the fair market value in the appraisal and net book value (assumption "price"). Thus, there was no *bona fide* sale.

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 BIHA 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 the loss 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 Massachusetts 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 BIHA which then became known as BIDMC, with the Provider ceasing to exist. As the surviving corporation, BIHA acquired all of the assets and assumed all the liabilities associated with the operations of the Provider.

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. . . .
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> (ii) *Statutory merger between related parties*. If the statutory merger is between two or more related corporations (as

[4] 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

> 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 BIHA 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.
>
> (2) *Common Ownership*. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.
>
> (3) *Control*. Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

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 by also considering the relationship between the parties according to the rights created by the contract. Therefore, 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 PM 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 approximately 30% of the individuals on the board of trustees of the new entity had previously served on the merging provider's boards, 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 section 4502.6 of Medicare's Intermediary Manual (CMS Pub. 13-4). 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 finds that Transmittal A-00-76, published long after the transaction in issue here, is not a clarification of policy but a change in interpretation. Evidence at the hearing, including a former HCFA manager's testimony and HCFA correspondence, shows that in prior interpretations, relatedness for a merger transaction was determined solely on relationships prior to the merger. [5]

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 even though 30% of BIDMC and 34.5% of CareGroup Board of Directors were individuals who had previously served on the Provider's board, 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). Moreover, there also was no longer a "provider entity" to benefit from these board members actions. There was no crossover of board members during the negotiation. Once the merger was completed, the board members who crossed over to the surviving corporation would be duty bound to act in the best interest of the surviving corporation. Testimony by Board of Director members further shows that no significant influence actually occurred. Rather, the evidence clearly indicates the policies and operations were consistently dominated by the surviving corporation.[6] Likewise, the Provider's managerial and clinical staff that continued to work for the surviving corporation had minimal influence in comparison to the individuals associated with the surviving corporation before and after the merger.[7]

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 PM, Pub. 60A

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[5] See, 1977 letter, Provider Exhibit P-108; 1987 Geller letter, Provider Exhibit P-109; 1994 Booth letter, Provider Exhibit P-79.

[6] 1 Transcript (Tr) at 87-89; 295-297; 280-282.

[7] 1 Tr. at 295-297; 280-289.

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." It 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 consideration must be regarded in applying that regulation section to non-profit mergers and consolidations." It directs the Intermediary to determine if a *bona fide* sale has occurred. The Board finds this concept to be substantive; therefore, since the changes were not published with the notice and comment period required by the Administrative Procedure Act, it is a retroactive change that cannot be applied in this case.

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. In May, 2000, a *bona fide* sale definition was added to the manual as follows: "a bona fide sale contemplates 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."[8] The PM's definition of *bona fide* equates "reasonable compensation" with the fair market value of assets.

The Board finds the concept of requiring a merger to conform to an outright sale to be a new substantive requirement. Until 1977, the regulation on depreciation did not specifically include mergers, although it did cover other types of transactions. In 1977, the Secretary proposed adding a section on mergers and consolidations. 42 F.R. 17486 (April 1, 1977). When mergers and consolidations were added to the list of transactions that could potentially trigger a depreciation adjustment, the preamble to the final regulation uses the term "bona fide transaction" rather than "bona fide sale" as used in 42 C.F.R. §405.415(f)(2)(1979). The Board considers this language significant to indicate that the Secretary did not consider mergers and consolidations as sales. Because the PM change requiring mergers and consolation to conform to characteristics of a sale was not published with the notice and comment period required by the Administrative Procedures Act, it is, therefore, retroactive and cannot be applied to this transaction.

The Board does find that the transaction here was *bona fide*. Black's Law Dictionary defines *bona fide* as:

> In or with good faith: honestly, openly, and sincerely; without deceit or fraud. Truly; actually; without simulation or pretense. Innocently; in the attitude of trust and confidence; without notice of fraud, etc., real, actual, genuine, and not feigned.

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

The evidence clearly shows this merger to be *bona fide* under the Black's Law Dictionary definition. Negotiations with several potential candidates are well documented. Starting in 1993, the Provider approached several area hospitals about forming some type of alliance.[9] Its initial overtures to BIHA were rejected and in late 1994, the Provider approached New England Medical Center (NEMC) about a merger.[10] After several months of negotiations, the parties executed a Memorandum of Understanding memorializing their intention to merge, but those plans collapsed in July 1995.[11] After other hospitals rejected an alliance, the Provider approached BIHA again about a merger.[12] After several negotiating sessions, the parties determined that this merger plan also would fail. The parties were able to reestablish talks and finally reached an agreement.[13] The merger was an arms-length transaction between a willing and well informed buyer and seller, neither being under coercion, for reasonable consideration. The parties were unrelated, each acting in its own self-interest.

Even if the *bona fide* sale criteria were applicable, the Board nevertheless finds the Provider in the circumstances here to have received "reasonable consideration." The Provider initially calculated the loss it claimed by comparing the amount allocated to depreciable assets with the net book value. This produced a Medicare loss of over $8 million dollars and the intermediary disallowed the loss. The Provider obtained an appraisal shortly before the hearing and recalculated its loss based on the appraised value of the assets, which produced a significantly greater loss.[14] The Intermediary urges the Board to discount the appraised value because the appraisal occurred several years after the transaction. Regardless of the figures used by the Provider to calculate the loss, the Intermediary found the disparity between the consideration (that portion of the amount of liabilities assumed allocated to the depreciable assets) and the fair market value of those assets (which the Intermediary apparently equates to net book value) to be indicative of lack of a *bona fide* sale.

The Board first notes that the regulatory concept of a depreciation adjustment would be unnecessary if net book value could be considered fair market value; therefore, the Board does not consider the disparity between the consideration allocated to the depreciable assets and net book value determinative.

The direct evidence of fair market value other than the appraisal is limited. The Provider was not interested in selling its assets outright and it is undisputed that no negotiations along this line occurred.[15] Rather, the emphasis was on the declining revenues and changing market forces that would inevitably force the Provider out of business in the next few years unless it found another health care provider with which to form some type of alliance or merger. It had considerable debt that it had been unable to pay from its operating margins (1-2% in the years prior to the merger) and had been dipping into its

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[9] See Provider Exhibit 13.
[10] See Provider Exhibits 18-21.
[11] See Provider Exhibits 22-34.
[12] See Provider Exhibits 37-42.
[13] See Provider Exhibit 48.
[14] See Provider Exhibit and Provider's Revised Final Position Paper 15-16.
[15] Tr. 96-97

investments for debt service and some renovations and replacements of plant and equipment.[16] Its buildings were built from the early 1900s through 1995 with most built in the 1950s through the 1970s. Its 1995 building represented over half of the appraised value of the 12 buildings that comprised Provider's hospital campus.[17] Some of the older buildings still had 4-bed wards.[18] These facts, coupled with the changing market conditions that spurred hospitals to combine operations to eliminate duplicate services and facilities support the Provider's claim that it suffered a genuine economic loss of value of its facilities and equipment, although quantifying that amount is difficult.

The most compelling evidence that there was no market for the buildings and equipment independent of the business enterprise is the fact that the Provider approached numerous health care providers about affiliating or merging but was rebuffed. The eventual merger with BIHA came only after the Provider repeatedly appealed to it and after difficult and lengthy negotiations. Throughout these efforts, apparently none of these other health care enterprises sought to take advantage of the Provider's weakened financial position to acquire the hospital facilities and equipment outright, including BIHA, located directly across the street and being financially and operationally stronger than the Provider. The Provider's multiple unsuccessful attempts to make a business deal are persuasive that having its liabilities assumed through merger was the best price it could obtain.

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. If there is disagreement or lack of documentation of fair market value, the intermediary "will require an appraisal" and will make the allocation accordingly. The Board has read this directive literally to require a pro-rata allocation to all assets even though it means discounting current assets and cash. This methodology results in a higher allocation to depreciable assets which diminishes the amount of the loss.

As to the Intermediary's objection to use of the appraisal conducted several years after the transaction, the Board agrees that a better appraisal could have been done closer to the transaction date with better records. However, the evidence is credible that the appraisal fairly took into account the condition of the assets at the time of the transaction and is reliable evidence of fair market value at the time of the transaction, particularly when considered in light of the difficulty the provider had in finding any health care organizations with interest in acquiring its business assets.

In computing the Provider's loss, the amount should be reduced by the depreciation expense that was claimed on the merged assets by the surviving corporation. This adjustment, commonly referred to as the "DEFRA adjustment," is necessary because the merger transaction was treated as a pooling of interests for accounting purposes, and the value of the assets transferred to Beth Israel in the merger was not written down. As a result, Beth Israel

[16] Tr. at 111-118.
[17] See Provider Exhibit 12 and Tr. 108-109.
[18] Tr. at 109

continued to claim depreciation for these assets at their carrying value on the Provider's books at the date of the transaction without considering the decline in their value as evidenced by the loss.

DECISION AND ORDER:

The Intermediary's adjustment disallowing the Provider's claimed loss on disposition of assets due to a change of ownership resulting from a statutory merger was contrary to the regulatory requirements of 42 C.F.R. §413.134(l)(2)(i) and is reversed. The allocation of the consideration to the merged assets should be performed based on the Provider's submitted appraisal using the pro-rata method discussed at 42 C.F.R. §413.134(f)(2)(iv).

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

Suzanne Cochran
Chairperson

DATE: May 29, 2009