PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D34

PROVIDER -
Whidden Memorial Hospital
Everett, Massachusetts

Provider Nos.: 22-0042; 22-5699

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services - Maine

DATES OF HEARING
April 18-19, 2007

Cost Reporting Periods Ended -
July 31, 1996; September 30, 1996;
September 30, 1997; September 30, 1998

CASE NOs.: 99-1786; 99-2499;
00-2047; 01-1820

INDEX

ISSUES:

1. Whether the Intermediary's audit adjustments disallowing the entire loss on the disposition of assets claimed by the Provider, when the Provider corporation merged with another provider corporation, were appropriate.

2. Whether the Intermediary properly denied the Provider's application for a new provider exemption from the routine service cost limits (RCLs) for its hospital-based skilled nursing facility (HB-SNF).[1]

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

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

ISSUE #1 – Loss on Merger

Under the Medicare regulations in effect during the years in issue, a provider was entitled to claim as a reimbursable cost the depreciation (i.e., the loss of value over time) of property, plant and equipment used to provide health care services 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 prorated over the asset's estimated useful life in accordance with an acceptable depreciation method. 42 C.F.R. §413.134(a)(3). Providers were then reimbursed for a percentage of the annual depreciation based on the extent to which the asset was used for the care of Medicare patients.[2]

[1] Also known as, Whidden Memorial Hospital Transitional Care Unit (TCU).

[2] The Medicare Act has been amended to change the method of payment for capital assets.

Because the calculated annual depreciation was only an estimate of the asset's declining value, the regulation at 42 C.F.R. §413.134(f) provided for an adjustment to reimbursable depreciation where a provider incurred a gain or loss on the disposition of a depreciable asset.[3] If an asset was disposed of for less than the depreciated basis calculated under Medicare (net book value), then the asset's loss in value (i.e., depreciation) would exceed the depreciation estimated (and reimbursed) for Medicare purposes. Accordingly, the provider would receive additional reimbursement in the form of a depreciation adjustment. Conversely, if a provider received consideration for a disposed asset that was greater than the depreciated basis, then a "gain" had occurred, and the Medicare program would recapture its share of depreciation previously paid to the provider.

In 1979, CMS extended the depreciation adjustment to "complex financial transactions" not previously addressed in 42 C.F.R. §413.134(f) by including mergers and consolidations. 42 C.F.R. §413.134(l). 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, a statutory merger between related parties would not trigger a depreciation adjustment. 42 C.F.R. §413.134(l)(2)

Medicare's rules regarding "relatedness," 42 C.F.R. §413.17, state 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.

42 C.F.R. §413.17

In 1987, CMS issued a set of instructions to its fiscal intermediaries on various types of provider organizational structures, the most frequent types of transactions affecting ownership of these structures, and the Medicare reimbursement treatment of such transactions. See, Section 4502 of the Medicare Intermediary Manual (MIM) (CMS Pub. 13-4).

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[3] A depreciation adjustment for a gain or loss was removed from the program's regulations effective December 1, 1997.

Section 4502.1, entitled "Provider Organizational Structures," explains that a corporation can be one of the three basic types of organizational structures, and can be organized either as a for-profit or non-profit entity. Section 4502.6, entitled "Statutory Merger," addresses the reimbursement consequences of a merger involving two or more corporations, as follows:

> A statutory merger is the combination of two or more corporations pursuant to the law of the state involved, with one of the corporations surviving the transaction. Medicare program policy permits a revaluation of assets acquired in a statutory merger between unrelated parties, when the surviving corporation is a provider. . . .
>
> EXAMPLE:
>
> Corporation A (a non-provider) signs an agreement of merger consistent with the principles of applicable state law with corporation B, the provider, with corporation A surviving. Corporation A will be operated as a provider. Corporations A and B were unrelated parties prior to the transaction. . . .
>
> [The fiscal Intermediary] determines that the transaction constitutes a CHOW for Medicare reimbursement purposes since corporation A will be operated as a provider. A gain/loss to the seller and a revaluation of the acquired assets to the buyer are computed.
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> (Emphasis added).

ISSUE #2 – SNF New Provider Exemption

42 U.S.C. §1395 x(v)(1)(A), authorizes the Secretary to establish prospective limits on provider costs that are reimbursed under Medicare. Through regulation, the Secretary established limits on routine care costs, referred to as routine cost limits (RCLs). The Medicare regulations at 42 C.F.R. §413.30(c) permit providers to obtain relief from the cost limits by requesting a reclassification, exception or exemption.

CMS provides an exemption from the cost limits for approximately the first three years of operation for "new providers." 42 C.F.R. §413.30(e); 44 Fed. Reg. 31802 (June 1, 1979). The exemption may be granted if the provider "has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years. An exemption . . . expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient." 42 C.F.R. §413.30(e).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Everett Cottage Hospital d/b/a Whidden Memorial Hospital (Provider or Whidden) is a non-profit, general acute care hospital located in Everett, Massachusetts. The fiscal years under appeal are July 31, 1996, September 30, 1996, September 30, 1997 and September 30, 1998.

Effective August 1, 1996, the Provider merged with another Massachusetts non-profit corporation named the Melrose-Wakefield Hospital Association which owned and operated a community hospital in Melrose, Massachusetts, known as Melrose-Wakefield Hospital. The Provider submitted a terminating cost report for the period ended July 31, 1996, on which it claimed a loss on statutory merger. Upon audit of the Provider's cost report, Association Hospital Service of Maine[4] (Intermediary) disallowed the entire loss claiming that the statutory merger did not meet the requirements of a bona fide sale. The disallowance of the loss was reflected in a NPR dated September 21, 1998.

On March 4, 1996, the Provider opened a new transitional care unit (TCU) to provide skilled nursing care on its campus. On March 8, 1996, HCFA certified the TCU as eligible to participate in the Medicare program as a skilled nursing facility (SNF). On June 2, 1997, the Provider submitted an application requesting a new provider exemption from the SNF routine cost limits effective through the cost reporting period ending September 30, 1999. [5] On August 21, 1997, the Provider was notified by its Intermediary that HCFA had denied its request for a new provider exemption on the basis that the Whidden TCU did not meet the criteria for a new provider.

The Provider timely filed its requests for hearing with the Board pursuant to 42 C.F.R. §§405.1835-1841, challenging the disallowance of the loss on the disposal of assets and the denial of the new provider exemption request and has met jurisdictional requirements. The Provider was represented by Richard P. Ward, Esquire, of Ropes & Gray LLP. The Intermediary was represented by Arthur E. Peabody, Jr., Esquire of Blue Cross Blue Shield Association.

ISSUE#1 – LOSS ON MERGER

STIPULATIONS OF THE PARTIES:

The parties have entered into the following stipulation of facts relating to the loss on merger issue:

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[4] Associated Hospital Service of Maine, now known as National Government Services- Maine, took over the responsibilities of Blue Cross and Blue Shield of Maine.

[5] At the time the request was submitted, the Provider sought exemption for the TCU for the entire period from March 8, 1996 to September 30, 1999. Subsequent to submission of the request, HCFA implemented a prospective payment system for long-term care facilities, effective for the Provider's cost reporting year beginning October 1, 1998. The new reimbursement system thus limits the applicability of the exemption to the period from March 8, 1998 to September 30, 1998. See, Provider's Final Position Paper at 14.

1. Prior to August 1, 1996, Everett Cottage Hospital, d/b/a Whidden Memorial Hospital (WMH), was a Massachusetts non-profit corporation. It had no corporate parent.

2. Prior to August 1, 1996, WMH owned and operated a duly licensed community hospital in Everett, Massachusetts, known as Whidden Memorial Hospital, which hospital participated in the Medicare program as Provider 22-0042.

3. Prior to August 1, 1996, Melrose-Wakefield Hospital Association ("MWHA") was a Massachusetts non-profit corporation that owned and operated a duly licensed community hospital in Melrose, Massachusetts, known as Melrose-Wakefield Hospital, which hospital participate in the Medicare program as Provider No. 22-0106.

4. Prior to August 1, 1996, the corporate parent of MWHA was a Massachusetts non-profit corporation named Melrose-Wakefield Healthcare Corp (MWHC).

5. At all times prior to August 1, 1996, WMH and MWHA had no common board members or officers and had no common ownership interest in each other.

6. On June 1, 1994, WMH and MWHC executed a non-binding Letter of Intent. On October 12, 1995, WMH [sic] and MWHC executed a Memorandum of Understanding ("MOU"). On July 31, 1996, WMH and MWHA executed a Plan and Agreement of Merger ("PAM").

7. Effective August 1, 1996, the Provider, WMH, consummated a statutory merger into MWHA by filing on August 1, 1996 Articles of Merger with the Secretary of the Commonwealth of Massachusetts. MWHA was the surviving legal entity and changed its name to Melrose-Wakefield Healthcare Corp. Also effective August 1, 1996, the parent of the Surviving Entity was renamed Unicare Health Systems, Inc. As a result of the statutory merger as of August 1, 1996, WMH ceased to exist and MWHA assumed all of the assets and all of the liabilities of WMH. After the merger, the Board of Trustees of MWHA consisted of sixty (60) members. Of the sixty members of the Board of Trustees of MWHA after the merger eleven (11) had previously been members of the Board of Management of WMH. These individuals include David Allan, Michael DeLeo, George Keverian, Dennis Leonard, Arthur MacKinnon, Leonard McDonald, Richard O'Neil, Joseph Sequeira, Jonathan Strongin, Fred Tavano, and Ezio Tesone. Of the sixty (60) members of the Board of Trustees of MWHA, two (2) were former trustees of WMH. These individuals include Italo Evangelista and Carmen Mercadante. An additional five (5) members of the Board of Trustees of MWHA were previously Members of WMH. These individuals include Paul Delory, Francis LaRovere, Lester MacLaughlin, George McCarthy, and Marjorie White.

8. After the merger, the Executive Committee of MWHA consisted of twenty-four (24) members. Of the twenty-four (24) members, at least eight (8) were former

trustees of WMH or former members of the Board of Management of WMH. These individuals include Michael DeLeo, Italo Evangelista, George Keverian, Dennis Leonard, Arthur MacKinnon, Leonard McDonald, Richard O'Neil, and Jonathan Strongin.

9. Two (2) individuals formerly associated with WMH were appointed as officers in the merged corporation (MWHA); one as Secretary Clerk; the other as First Vice-Chairman. In addition, two (2) individuals formerly associated with WMH were appointed as officers in the parent company (Unicare Heath System); one as Secretary Clerk; the other as First Vice-Chairman. These individuals were Dennis Leonard, Arthur MacKinnon, Leonard McDonald, and Richard O'Neil.

10. After the merger, 101 former members or corporators of WMH were added to the existing membership of the Melrose-Wakefield parent corporation or UniCare Health Systems, Inc. making a total membership of 346 members.

11. WMH filed a claim for a loss on disposition of its assets on its terminating cost report for the fiscal year ending July 31, 1996.

12. Ross T. France would testify as set forth in his Affidavit in Provider Exhibit 102 (P-102).

13. Peter G. Kritikos would testify as set forth in his Affidavit in Provider Exhibit 103 (P-103).

PROVIDER'S CONTENTIONS:

Market Conditions

The changing market conditions in the early 1990's led the Provider to believe that Whidden Memorial Hospital could not survive as an independent hospital. At a time when managed care plans were increasing their share of the market, Whidden had no managed care contracts with any of the major managed care companies. In the absence of any major managed care contracts and competition from large teaching hospitals seeking to increase their market share, the Provider was unable to retain a sufficient number of physicians or to invest in more sophisticated and costly medical equipment and facilities. These factors contributed to a decline in patient utilization which in turn caused a decline in the Provider's operating revenues. From FY 1993 to FY 1994, actual operating losses increased from $676,000 to over $950,000 [6]and net income in 1994 fell to only $27,990.[7]

[6] Transcript at 65. See, Provider Exhibit P-5.
[7] Tr. at 67-68. Id.

Intent to Merge

During 1992 and 1993, the CEO and CFO made it generally known that Whidden was looking for a buyer or a hospital with which it could merge. Hospital senior management began contacting nearby hospitals and hospitals systems to determine if they had any interest in purchasing or merging with Whidden. The CEO or the CFO had meetings with several non-profit large teaching hospitals in the state as well as with several neighboring community hospitals to discuss the possibility of a sale or a merger. Melrose-Wakefield Hospital was the only hospital that had any interest in purchasing or merging with Whidden.[8]

During 1993, the Provider proceeded with discussions with Melrose-Wakefield Hospital Association and in June of 1994, Whidden and Melrose-Wakefield Healthcare Corporation signed a Letter of Intent. The Letter of Intent committed the parties to evaluate whether it would be in the best interests of each to move forward with some form of affiliation whether through sale, merger or consolidation, and established a Study Committee, composed of five persons representing the interests of Whidden and five persons representing the interests of Melrose-Wakefield. The Study Committee engaged Coopers & Lybrand to prepare a report on market trends, the potential costs and cost savings of a merger, and projections for each hospital without a merger. For Whidden, the projections showed growing losses in every respect.[9]

For Whidden, the report by Coopers and Lybrand projected that while area hospitals' volumes were projected to increase, the Provider's volume was projected to steadily decline, with the rate of decline virtually tripling between 1995 and 1997.[10] Moreover, the debt service ratio, an indicator of how much operating income is available to pay debt obligations, was projected to be less than 1 by 1997. This meant that Whidden would be in violation of covenants on its $11 million in Massachusetts Health and Educational Facilities Authority (MHEFA) bonds, thus potentially triggering bondholders to call their bonds, which could immediately put the hospital into bankruptcy.[11]

On October 12, 1995, the Provider entered into a Memorandum of Understanding regarding the parties' intent to merge and on July 31, 1996, a Plan and Agreement of Hospital Merger was signed. The following day, on August 1, 1996, Articles of Merger were filed. From the time of the signing of the Letter of Intent in 1994 until the Plan and Agreement of Hospital Merger was signed in 1996, the parties continued to negotiate over the terms of a sale or merger. With respect to monetary consideration, the Provider asked and was told that Melrose-Wakefield had no interest in paying cash or allowing Whidden to carve out and retain any of the liquid assets. Melrose-Wakefield would only proceed if they assumed all assets and all liabilities, therefore a sale was not an option and the deal would only proceed as a statutory merger in which Melrose-Wakefield was the surviving corporation. One issue which lengthened the time period between the 1994

[8] Exhibits P-102 and P-103.
[9] Exhibit P-102.
[10] Provider's Post Hearing Brief, page 30.
[11] Tr. at 92-94.

Letter of Intent and the merger in 1996 was a mandatory arbitration clause in the nurse union contract which Melrose-Wakefield was not willing to accept. The Provider was able to get this provision removed from the union contract but it took an extensive period of time to do so.

Effective August 1, 1996, the Provider merged into Melrose-Wakefield Hospital Association, the surviving entity, which changed its name to Melrose-Wakefield Healthcare Corp. Also effective the date of merger; the corporate parent of the surviving entity was renamed Unicare Health System, Inc. The surviving entity operated Whidden Memorial Hospital and Melrose-Wakefield Hospital as separate hospitals, each with its own license and Medicare and Medicaid numbers. The Stipulations of the Parties outlines the changes in each hospital's Board of Trustees and Board of Management.

Recognition of the Loss

42 C.F.R. §413.134(1)(2) establishes only two requirements for recognition of a loss (or gain) on disposition of assets when a provider corporation merges into another corporation, with the other corporation surviving: (1) the merger must be a statutory merger, and (2) the corporations must be unrelated as specified in 42 C.F.R. §413.17. The Provider contends that the requirements for recognition of a loss on statutory merger have been satisfied, and consequently it is entitled to recognition of its loss.

The parties have stipulated that the merger between the Provider and Melrose-Wakefield Hospital Association was a statutory merger between unrelated parties and that prior to the transaction, Whidden Memorial Hospital and Melrose-Wakefield Hospital Association were not subject to common control or common ownership.[12] In addition, the Provider contends that following the merger, Melrose-Wakefield Healthcare Corp.[13] was not subject to the control or significant influence of any individual(s) or organization that had been able to control or significantly influence Whidden prior to the merger.[14]

The Medicare regulations require that a gain or loss be recognized when, as here, a statutory merger takes place between unrelated corporations. Based on the plain language of the merger provisions of §413.134(1)(2)(i), determination of relatedness must be made prior to the merger. A determination of relatedness could not be made subsequent to the merger since, at that point, only one of the two corporations would exist. CMS's current interpretation of the regulation to require a review of relatedness subsequent to the merger is not only contrary to the plain language of the regulation, but also contrary to well established CMS policy which required a pre-merger, not post-merger, analysis of relatedness. The Provider argues that both Section 4502 of the Medicare Intermediary Manual[15] and authoritative guidance from the agency's Director

[12] Stipulation 5.
[13] The surviving legal entity changed its name from Melrose-Wakefield Hospital Association to Melrose-Wakefield Healthcare Corp.
[14] Stipulations 7-10.
[15] Exhibit P-26, page 3

of the Office of Payment Policy in the Bureau of Policy Development[16], support the Provider's interpretation of pre-merger analysis of relatedness.

The Provider cites numerous PRRB decisions which support its arguments that the merger provisions at 42 C.F.R. §413.134(l)(2)(i)require a pre-merger, not post-merger analysis of relatedness. In Iowa Lutheran Hospital v. BlueCross BlueShield Association/Cahaba Government Benefits, PRRB Hearing Dec. No. 2007-D1, rev'd CMS Administrator Dec. (December 8, 2006), the Board rejected the intermediary's argument of post-merger relatedness and held that the regulation "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 also found similarly in UPMC - St. Margaret Hospital v. BlueCross BlueShield Association/Veritus Medicare Services, PRRB Hearing Dec. No. 2006-D23 rev'd CMS Admin. Dec. (July 25, 2006), Robert F. Kennedy Medical Center v. BlueCross BlueShield Association, PRRB Hearing Dec. No. 2005-D9, rev'd CMS Admin. Dec. (February 10, 2005) and Germantown Hospital and Medical Center v. Mutual of Omaha Insurance Company, PRRB Hearing Dec. No. 2004-D36 rev'd CMS Admin. Dec. (October 28, 2004).

The Provider argues that even if a post-merger analysis of relatedness were required, there is no evidence to support a finding of relatedness post-merger. The 18%[17]of the Board of Trustees for Melrose-Wakefield Hospital Association after the merger who had been members of the Whidden Board of management prior to the merger, lacked the power to significantly influence or direct any action or policies of the board post-merger. The Provider emphasized that Melrose-Wakefield was adamant that it would have full control of Whidden's assets post-merger and the merger documents were deliberate in ensuring that the previous Whidden board would no longer have control over Whidden's assets post-merger.[18]

The Provider also argues that the Intermediary's allegations that a "bona fide" sale is necessary to allow gains or losses to be recognized, is contrary to the regulation and should be afforded no weight. The transaction between the parties was a merger, not a sale. 42 C.F.R. §413.134(1)(2)(i) specifies that where a statutory merger between unrelated parties exists, the merger is subject to §413.134(f) which specifies the methods to be used to calculate a loss on a bona fide sale. However, nothing in the regulations suggest that mergers must themselves meet the "bona fide" criteria, but rather the same methodology must be used to compute losses on statutory merger between unrelated parties as on a bona fide sale.

The disallowance of the Provider's loss cannot be sustained based on the Intermediary's determination that the consideration was unreasonable. Since the loss resulted from a statutory merger, the requirements related to purchase and sale of assets are irrelevant to

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[16] Exhibit P-91.

[17] See Stipulation 7 and Provider Exhibit P-102. Accordingly only eleven (11) of the sixty (60) Board of Trustees of Melrose-Wakefield Hospital Association, or 18%, had held similar positions of governance power and responsibility at Whidden Memorial Hospital.

[18] Exhibit P-102, ¶ 17-20.

recognition of that loss. The Intermediary must bear the burden of demonstrating that bona fide sale requirements are applicable, and that those requirements were not satisfied.

The Provider contends that even if the bona fide sale criteria were applicable to mergers, this merger would satisfy those criteria in that the merger also met the criteria of the Provider Reimbursement Manual (PRM) Section 104.24 (May 2000) which states:

> A bona fide sale contemplates an arm's length transaction between a willing and well informed buyer and seller, neither being under coercion, for reasonable consideration. An arm's length transaction is a transaction negotiated by unrelated parties, each acting in its own self interest.

Due to the changing market conditions and forecasted financial decline, the Provider sought to be purchased or to merge with another entity. Those financial conditions were documented with testimony from Whidden employees. The Provider argues that $19 million was reasonable consideration for the acquisition of Whidden assets as a going concern hospital. The Provider provided testimony at hearing that although Whidden's monetary and non-monetary assets were valued at $27 million, this valuation was done on the basis that the highest and best use of the property was not as a hospital[19] and that the "subject property would not be purchased for use as a hospital by any reasonable buyer".[20] The Provider's witness also stated that had the appraisal been completed assuming the hospital would continue operations, the assessment would necessarily have been lower, which would have lowered the fair market value of the assets. In addition, since Whidden was heading toward bankruptcy and was not considered a going concern, significant resources would be needed to invest in the Provider in order to turn the hospital around. This investment of approximately $1.5 million would also need to be considered in determining the fair market value of the assets.[21]

The Provider has calculated the loss using two methods, the Booth pro-rata method which is referenced at §413.134(f)(2)(iv) and supported by CMS personnel[22] and an alternative allocation method referenced in Accounting Principles Board Opinion 16 (APB 16). The Provider contends that under the prescribed Booth pro-rata method, cash is treated as having a fair market value below its face value – which is clearly inappropriate. The APB 16 method avoids this deficiency. The Provider contends that its calculations of the loss of which Medicare's share prior to DEFRA adjustments is $4,525,956 under the Booth pro-rata method or $4,713,426 under APB 16 should be accepted.[23] The Booth pro-rata loss was calculated by allocating the lump-sum consideration (liabilities assumed) proportionately among all the assets transferred, including cash, based on the net book value of the assets. The APB 16 loss was calculated by first allocating the lump-sum consideration to cash on a dollar for dollar basis, and then allocating the remaining consideration to non-monetary assets on the basis of relative fair market value.

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[19] See, Provider Exhibit P-14 at 13 and Tr. 96.
[20] Tr. 99-100.
[21] Tr. 127-129.
[22] See Provider Exhibit 89.
[23] See, Provider Exhibits P-59 through P-69.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider is not entitled to a loss on disposition of assets by merger because it fails to meet the standards as set forth in the regulations. The Intermediary asserts that the "sale" was between related parties and did not meet the criteria of a "bona fide" sale.

First, the Intermediary argues that the relatedness of the parties must be reviewed post-merger. The Intermediary argues that Whidden had significant influence or control over the surviving hospital and its parent corporation post-merger. The Intermediary asserts that former officers, board members and other designated members of the Provider became trustees, officers or served on executive committees of the newly merged entity and held approximately 30% of those positions of influence or positions of responsibility with the new entity.[24] The Intermediary also asserts that the relationship between the parties' post-merger is relevant. It shows that the assets never really changed hands and that the Provider continues to have control over its assets.

Even if the Provider can convince the Board that the parties were in fact not related, and the merger was the equivalent of a sale, 42 C.F.R. §413.134(f)(2) only allows gains and losses to be recognized for "bona fide" sales. The Intermediary argues that neither party associated with the merger can be considered a "bona fide" purchaser because both failed to meet the definition of a "bona fide" purchaser in the following respects: 1) the full price for the property was not paid (or even determined prior to the transaction), and 2) Melrose-Wakefield Hospital Association/Melrose-Wakefield Healthcare Corp. advanced no new consideration. The Intermediary asserts that when the entities merged, Melrose-Wakefield simply received all of Whidden's assets and liabilities; there was no indication that price was ever a consideration.

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 as follows. The parties have stipulated that prior to the merger the Provider and Melrose-Wakefield Hospital Association were unrelated parties as that term is defined in the regulatory provisions of 42 C.F.R. §413.17. Accordingly, the Board finds that a revaluation of the assets and a recognition of the loss incurred as a result of the merger of these unrelated parties is required under the specific and plain meaning of 42 C.F.R. §413.134(l)(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(l)(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 Melrose-Wakefield Hospital Association and ceased to exist. Under the terms of the transaction, Melrose-Wakefield Healthcare Corporation (the newly named surviving

[24] See, Intermediary's Final Position Paper at 63 and the Intermediary's Post Hearing Memorandum at 9.

corporation) acquired all the assets and assumed all the liabilities associated with the operations of the Provider.

Under regulations set forth at 42 C.F.R. §413.134(l)(2), the effect of a statutory merger upon Medicare reimbursement is as follows:

> (i) *Statutory merger between unrelated parties*. If the statutory merger is between two or more corporations that are unrelated (as specified in §413.17), the assets of the merged corporation(s) acquired by the surviving corporation may be revalued in accordance with paragraph (g) of this section. If the merged corporation was a provider before the merger, then it is subject to the provisions of paragraphs (d)(3) and (f) of this section concerning recovery of accelerated depreciation and the realization of gains and losses. . . .

The Board finds the plain language of the regulation dispositive. 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.

However, the Board finds that even if the related party concept was applied to the entities post-merger, the percentage of Provider "members" who obtained positions on the surviving entity's board does not constitute sufficient control. The Board acknowledges that both parties have supplied somewhat different analyses of the percentage of influence or control by the Provider post-merger, but finds the Provider's analysis of the carryover positions to be more accurate than the Intermediary's. The Intermediary's analysis includes the same individual in several different positions, which may not be inappropriate but which would inflate that percentage. In addition, the Board also notes that the top two (2) key employees for the Provider, the CFO and CEO, no longer held comparable positions at the merged facility, and eventually left to pursue other opportunities.

Historically, it is clear that CMS has not applied a "bona fide" sale requirement to statutory mergers between unrelated organizations. Such a requirement is not found in the opinion letter written in 1987 by then HCFA official William J. Goeller, Director of the Agency's Division of Payment and Reporting Policy[25] or the Medicare Intermediary Manual (MIM), Pub. 13-4, Section 4502 issued in 1987, or the opinion letter written in 1994 by Charles R. Booth, the Agency's Director of the Office of Payment Policy.[26] Based on the authorities referenced above, once a transaction is acknowledged to be a statutory merger between unrelated parties, the conclusion follows immediately that the provider is entitled to recognition of a loss or gain on disposition of its assets. In no

[25] See, Provider's Exhibit P-90.
[26] See, Provider's Exhibit P-91.

instance is there a requirement that the merger meets the bona fide criteria applicable to sales.

The Intermediary's argument for denying recognition of the Provider's loss on merger because it is not a bona fide sale does not bear scrutiny. A sale between two corporations typically involves one corporation acquiring one or more of the assets for cash. By contrast, a merger between two corporations necessarily involves one corporation acquiring all of the assets of the other corporation in exchange for the assumption of all of the other corporation's liabilities. The transaction between Whidden and Melrose-Wakefield was specifically a merger. 42 C.F.R. §413.134(1)(2) does not restrict recognition of gains and losses to "bona fide" sales. The purpose of 42 C.F.R. §413.134(1)(2) is to allow recognition of a gain or loss in certain mergers. If a merger must be a sale before it can qualify for recognition of a gain or loss, then no mergers would qualify and Section 413.134(1)(2) of the depreciation regulation would be a nullity.

However, even if the Board was to find that the transaction had to meet the definition of a "bona fide" sale, the Board finds that the evidence provided in the record is sufficient to support that this merger was in fact "bona fide." Testimony from the Provider's CEO confirms that the Provider did in fact seek monetary consideration from Melrose-Wakefield as part of the negotiation process for the merger and that the request was denied. However, given the dire financial straits of the hospital - the Provider had less than one month of payroll on hand and bankruptcy was looming - the Provider made the decision to merge with the one entity willing to acquire the hospital before the facility would have entered bankruptcy and been forced to close.[27] The evidence presented shows that the Provider did contact other hospitals to explore the potential for merger or acquisition and that even when Melrose-Wakefield was the only facility indicating any interest in merging with the Provider, negotiations over the purchase price took place prior to the Plan and Agreement of Hospital Merger being signed in 1996. The Board finds the testimony and the evidence persuasive that the hospital was in a grave financial situation and the severity of the financial situation was largely unchallenged by the Intermediary. The Board therefore finds that the $19 million assumption of liabilities reflected the fair market value of the Provider operations at the time that the merger took place.[28]

The fair market value of the each of the depreciable assets in issue for purposes of the allocation of purchase price must be based on the Provider's use of the assets at the time of the transaction. 42 C.F.R. §413.134(f)(2)(iv). The evidence showed the depreciable assets, particularly used as a hospital, had little, if any, value. The appraisal (Provider Exhibit 14) concluded that the "subject property would not be purchased for use as a hospital by any reasonable buyer" due to poor demographics, poor access and minimal visibility. Provider Ex. 14 at page 13. The highest and best use would be for development as a residential property, consistent with the surrounding area. Provider Ex.

[27] Tr. 80-91.

[28] The Board finds that the Provider accurately utilized the "best and highest" valuation from the appraisal for the purposes of determining the value of the assets.

14 at page 14. As to the hospital facility itself, only the shell was considered to have any value, estimated as $600,000, based on a sales comparison. Provider Ex. 14 at page 19. The cost approach was considered inappropriate due to the age and extensive external obsolescence. Provider Ex. 14 at page 17. Utilizing a lower value would only increase the loss calculation. The issue is deemed moot as an appraisal as a going concern hospital would only have produced a lower value.

The Provider identified two methods in which the loss could be calculated, the Booth pro-rata methodology prescribed by 42 C.F.R. §413.134(f)(2)(iv) or the APB 16 methodology. The Board finds that the Booth pro-rata methodology is required by the regulation. Pursuant to this methodology, the lump-sum consideration is allocated among all the assets acquired based upon the relationship of each individual asset's fair market value to the total fair market value of all of the assets in the aggregate.

ISSUE #2 – SNF NEW PROVIDER EXEMPTION

BACKGROUND

The Provider opened its 20-bed hospital-based skilled nursing facility (HBSNF) on March 4, 1996 in accordance with the requirements established by the state of Massachusetts for licensing long-term care facilities.[29] In order to establish a SNF in the state of Massachusetts, a provider must possess a determination of need (DON) from the Massachusetts Department of Public Health (DPH) granting it the legal right to establish a long-term care facility with a specified number of beds. In 1994, DPH adopted a policy that would allow hospitals to establish a HBSNF by permitting the hospitals to enter into agreements with existing Level III nursing homes in order to purchase the operating rights to Intermediate Care Facility (ICF) licensed beds. DPH established this new policy to further the development of subacute services and to allow Level III providers to gracefully exit the Long Term Care (LTC) industry. The purchase results in the nursing home's surrendering the operating rights related to its beds to the hospital, transferring its patients to suitable other providers, and then closing the facility. Upon the closure of the Level III facility and completion of renovations at the hospital, DPH grants the hospital a new license for a new facility (i.e Level II HBSNF). In this case, the Provider arranged for Care Well Manor Nursing Home, Inc., an unrelated Level III facility located in Malden, Massachusetts, to close and purchased the rights to operate Care Well's 23 beds at a purchase price of $300,000.[30]

In July of 1995, the Provider applied for and DPH approved a request for "transfer of site" of Care Well's operating rights for the beds to Whidden's campus located in Everett, Massachusetts. Care Well took action to relocate all of its residents, terminate its employees and wind down operations. On October 4, 1995, the transaction for the

[29] Skilled Nursing Care Facilities are classified as Level II Long-term Care Facilities. See Provider's Exhibit P-6 at 4.
[30] See Provider Exhibit P-12 at 1.

operating rights for the beds was finalized and on March 4, 1996 the HBSNF was issued its license and began operations.

In July 1996, the Massachusetts legislature established an alternative basis for the issuance of DONs. Under the 1996 Mass. Acts ch. 203 § 31, any hospital which was issued a DON under the previous process would have its prior DON superseded and replaced pursuant to the 1996 DON Act. Accordingly, on September 20, 1996, the Massachusetts DPH superseded the prior licensure that Whidden had opened and operated under since March of 1996, and replaced it with a DON under the 1996 DON Act. This new DON was made effective retroactively to March 4, 1996.

In its letter dated August 4, 1997,[31] CMS' denied the new provider exemption on the grounds that, on July 31, 1996, the Provider had merged into Melrose-Wakefield Hospital which already operated a Medicare certified hospital-based skilled nursing facility, and a single hospital could not establish more than one distinct part hospital-based skilled nursing facility.[32] However, although a merger of two corporations did take place on August 1, 1996, each provider retained its individual license and Medicare provider number. In a letter dated November 4, 1997, CMS recognized that the Provider and Melrose-Wakefield were related but participating as separate hospitals, and reinstated the Provider's sub-provider numbers.[33] CMS did not reevaluate its new-provider determination in light of the reinstatement.

STIPULATIONS OF THE PARTIES:

The parties have entered in to the following stipulation of facts relating to the new provider exemption issue:

1. Provider Exhibit P-71 is a copy of the Intermediary Exhibit I-18 but is organized by grouping the MMQ [Management Minutes Questionnaire] forms by patient to identify which forms apply to which patients. Patients are separately identified as Patients A through X, and one patient is identified as "No Letter."

2. Neil McCole would testify as set forth in his Affidavit in Provider Exhibit P-75 and will be made available for cross-examination by telephone.

3. Cecila McCole would testify as set forth in her Affidavit in Provider Exhibit P-76 and will be made available for cross-examination by telephone.

INTERMEDIARY'S CONTENTIONS:

Recognizing that under the reasonable cost reimbursement system, routine service cost limits may sometimes warrant an adjustment, 42 C.F.R. §413.30(e) established an

[31] See Intermediary Exhibit I-5 or Provider Exhibit P-26
[32] The term hospital was defined to include multiple components of an institution complex that function as a single hospital under the criteria contained in section 2024 of the state operation manual (SOM).
[33] Provider Exhibit 29.

"exemption" from the limit for certain new providers. This exemption was designed to provide a new provider with an increased payment to offset the underutilization of services that most providers experience in the first few years of operation. CMS argues that utilization is not a criterion used in determining whether a provider is a "new provider" except in the case of a relocation as described in the Provider Reimbursement Manual (PRM-1) §2533.1B.3. To determine if an institution qualifies as a new provider, CMS looks to the types of services that the institution provides(d) under present and previous ownership.

42 C.F.R. §413.30(e) defines a "new provider" as a "provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years." The Intermediary contends that the regulatory language is ambiguous with respect to how the Secretary should determine whether a "provider" has operated under "previous ownership". The Intermediary further contends that the statute at 42 U.S.C. §1395x(u) defines a "provider of services" to be, among other things, a skilled nursing facility (SNF) and a SNF is further defined by statute to be an institution or "distinct part" of an institution, 42 U.S.C. §1395i-3(a), §1395x(j). Therefore, the Intermediary reasons, a "provider" is a term of art in Medicare that can mean only a "portion" of a healthcare institution.

In light of the ambiguity of the regulation, the Intermediary argues that the Secretary has adopted a reasonable interpretation of the terms "previous ownership" and "provider", as found in PRM-1 §2604.1.[34] The Intermediary also asserts that PRM-1 §1500 identifies that the disposition of all or some portion of a provider's facility or its assets used to render patient care through sale. . . is a change of ownership for purposes of Medicare reimbursement if the disposition affects licensure or certification. More specifically, the Intermediary contends that a certificate of need (e.g. the right to operate) is an asset used to render patient care that directly affects licensure and certification of a provider entity.

Where the right to operate, or its equivalent, is purchased from an existing institution, the transaction is considered a change of ownership and a review of the "previous owner's" operations become necessary. Therefore, in this case, Whidden is required to document the types of care or services rendered under present and previous ownership so the Intermediary can determine if the facility provided skilled nursing care and related services for three or more years prior to being certified to participate in the Medicare program.

The Intermediary argues that the Provider has failed to meet its burden by not producing evidence that reflects the type of services provided to the residents at Care Well prior to

[34] Per the Provider's Post-Hearing Brief at 52. footnote 18. While §2604.1 was by Transmittal No. 400, removed and replaced as of September 20, 1997 by §2533.1, this new section is not applicable in this case because the events, including the application and denial of the exemption application, all occurred while §2604.1 was still in effect. See Maryland General Hospital v. Thompson, 308 F.3d 340, 347 n.3 (4th Cir. 2002) ("Because section 2533.1 did not exist at the time of the transaction giving rise to this case, we do not believe it is applicable.")

the transfer of ownership that occurred on October 4, 1995. The Intermediary asserts that the only documentation submitted by the Provider regarding skilled nursing services provided was for services rendered on or after March 4, 1996, but it did not cover the three year period to the opening of the SNF. The Intermediary also argues that the MMQ Turnaround documents filed by Care Well with the State of Massachusetts Department of Public Welfare for purposes of Medicaid reimbursement contain definitive evidence that the facility was "primarily engaged," in its entirety or a distinct part thereof, in the provision of skilled nursing care and related services for more than three years prior to March 4, 1996 (the Provider's Licensure date). Based upon the MMQs and Care Well's Medicaid cost reports, the portion of the patient population receiving skilled nursing and related services or rehabilitative service was 52% in FY 1992, 71% in FY 1993, and 73% in FY 1994.[35]

PROVIDER'S CONTENTIONS:

The Provider argues that prior to the briefings for this case in 2007, the Intermediary had issued no argument as to why the Provider's request had been denied other than the rationale expressed in its August 4, 1997 denial letter, which was technically superseded by CMS' letter dated November 4, 1997.[36] The Intermediary's new arguments for denying the new provider exemption, are unsupported and erroneous for the following reasons:

First, Whidden's TCU had not been previously owned or operated by Care Well. 42 C.F.R. §413.30(e) defines a new provider as ". . . a provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years." HCFA Pub 15-1 §2604.1 provides an example " . . .an institution that has been furnishing only custodial care to patients for two full years prior to its becoming certified as a hospital furnishing covered services to Medicare beneficiaries, shall be considered a "new provider" for three full years from the effective date of certification."

The Provider contends that the Intermediary is incorrect in its reasoning that Whidden purchased its DON for its TCU from Care Well, an "existing institution," and that Whidden is now the new owner of Care Well. Although the Provider did facilitate the closure of Care Well in order to obtain its bed rights as was the required procedure in the state of Massachusetts at the time, the Provider's DON came directly from the DPH pursuant to the 1996 DON Act. The DON issued by the Massachusetts DPH on September 20, 1996 superseded any previous DON issued and was effective as of March 4, 1996. Therefore, the Provider did not purchase or transfer any tangible assets from Care Well, and its payment to Care Well, to facilitate the closure of the Level III nursing home, would not qualify as a CHOW under MIM §4502.5. In addition, the Provider argues that in the State of Massachusetts, a DON is not an asset of any kind, but only a

[35] See Intermediary's position paper at page 50 and Exhibit I-48 for Medicaid cost reports and Exhibit I-18 for MMQ reports.

[36] The Intermediary's attorney, Mr. Peabody, conceded that the original basis for the denial is not applicable to these appeals and was a "mistake". See Tr. at pp. 151-155.

condition precedent for a person to proceed to make a substantial capital expenditure to construct a healthcare facility. It is simply an action taken by the DPH to allow an entity to construct a facility.

The Provider argues that the Board has correctly rejected the notion that the mere transfer of "operating rights" is sufficient to constitute a change of ownership for purposes of implementing the new provider exemption criteria in 42 C.F.R. 413.30(e). In Jordan Hospital, Plymouth MA v. BCBS/Associated Hospital Services, PRRB Hearing Dec. No. 2007-D23, (February 28, 2007), the Board was faced with virtually the same facts as in this case and concluded that Jordan Hospital was entitled to a new provider exemption under 42 C.F.R. §413.30(e) as it concluded ". . . that the purchase of the 'right to operate' does not, in itself, constitute a change in ownership (CHOW) and does not affect the Provider's right to a new provider exemption." The Board found similarly in Harborside Healthcare-Reservoir v. BlueCross and BlueShield Association/Empire Medicare Services, PRRB Dec. No. 2006-D14, January 25, 2006 and St. Gertrude's Health Center, Shakopee, Minnesota v. BlueCross BlueShield Association/Noridian Administrative Services, PRRB Dec. No. 2007-D38, May 23, 2007.

Second, if the Board rejects the Provider's arguments that the transfer of operating rights does not constitute a CHOW, the Provider argues that Care Well did not operate as the equivalent of a Medicare-certified skilled nursing facility in the three years prior to Whidden establishing the TCU within its facility. The controlling case is St. Elizabeth's Medical Center of Boston, Inc. v. Thompson, 396 F. 3d 1228 (D.C. Cir. 2005) which also involved a Massachusetts hospital and a Level III Medicaid nursing facility (NF) which CMS contended had operated as the equivalent of a certified Medicare SNF. The Court of Appeals rejected the CMS position that, since the alleged prior owner operated a Medicaid NF, as a matter of law it also operated as the equivalent of a Medicare-certified SNF because by statute it was allegedly required to deliver the same range of services. The Court correctly reviewed the statutory definition of a NF in 42 U.S.C. §1396r(a), the Medicaid statute, and compared it to the definition of a SNF in 42 U.S.C. §1395i-3(a), the Medicare statute.

The Medicaid statute defines a "nursing facility" as opposed to a "skilled" nursing facility. The Medicare statute defines a "skilled nursing facility" as one that, ". . . is primarily engaged in providing to residents – (A) skilled nursing care and related services for residents who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled or sick persons." 42 U.S.C. §1395i-3(a)(1). On the other hand, the Medicaid statute, while incorporating the definition in the Medicare statute, adds a third alternative definition and defines a NF as:

> . . . an institution (or distinct part of an institution) which
> (1) is primarily engaged in providing to residents -
>
> * * *
>
> or (C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition

> require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

42 U.S.C. §1396r(a)(1)(C).

As a result, St. Elizabeth's Medical Center, supra, held that a NF does not have to provide any skilled services to be a NF because it could primarily provide the custodial services set forth in the alternative section in 42 U.S.C. §1396r(a)(1)(C). In addition, the Court held that the Level III Medicaid nursing facility "was primarily engaged in providing custodial care to its residents" and while it "occasionally provided" skilled nursing services, such occasional skilled services were not sufficient to establish that the Level III Medicaid NF was "primarily engaged" in providing skilled care to its residents. The Provider contends that the CMS Administrator has also recognized that CMS is now obligated to utilize the criteria set forth in St. Elizabeth's Medical Center, supra, in determining if a facility was "primarily engaged" in providing skilled nursing or rehabilitative services.[37]

In order to clarify the statutory distinctions between a SNF and a NF, the Secretary has issued regulations and guidance to distinguish between "custodial care" which is not covered in a Medicare SNF and the type of "skilled nursing services" which are covered. Thus, in the Medicare regulations found at 42 C.F.R. §411.15(g), it defines custodial care as:

> "… any care that does not meet the requirements for coverage as SNF care set forth in §§409.30 through 409.35 of this chapter.

The regulations found at section 409.31(b) (1996) set forth the level of care requirements for post-Hospital SNF care:

> (1) the beneficiary must require skilled nursing services or skilled rehabilitation services, or both, on a daily basis.
>
> (2) those services must be furnished for a condition
>
> > (i) for which the beneficiary received inpatient hospital or inpatient RPCH services; or
> > (ii) which arose while the beneficiary was receiving care in a SNF . . . for a condition for which he or she received inpatient hospital or inpatient RPCH services.

42 C.F.R. §409.34 further elaborates on what is meant by the requirement that each beneficiary must receive skilled nursing care on a "daily basis"; it states:

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[37] See Provider Exhibit P-67, St. Joseph's Health Services of Rhode Island v. BlueCross BlueShield Association/BCBS of Rhode Island, CMS Administrator Decision, July 13, 2005.

> (a) To meet the daily basic requirement specified in §409.31(b)(1), the following frequency is required:
>
> (1) Skilled nursing services or skilled rehabilitation services must be needed and provided 7 days a week; . . .

The Provider contends that providing skilled nursing services only "occasionally" is not, as a matter of law, sufficient to make the Care Well NF's operations equivalent to a SNF which must be "primarily engaged" in rendering skilled nursing or rehabilitative services. The occasional skilled nursing services provided by Care Well to its residents, as a matter of law, merely constituted "custodial care." The evidence presented in the form of affidavits from the former owners of Care Well further support that skilled nursing services were only occasionally ordered by a physician and provided to residents and that the primary care furnished each day to each resident was custodial care to assist in the activities of daily living.[38]

In addition, the Provider argues that the Management Minutes Questionnaire (MMQ) forms submitted by Care Well to document its Medicaid services verify the testimony by the Care Well administrators. Each MMQ document includes custodial care activities such as hygiene, dressing, eating and continence, and the majority of MMQ forms indicate that custodial services only were provided. The Provider acknowledges that the evidence presented by the Intermediary is accurate in that certain "skilled" services or procedures such as debridement were rendered on intermittent occasion, but argue that if skilled services were needed, Care Well contacted a physician who would come to Care Well to treat the patient, or transported the patient by ambulance to a nearby acute care hospital.[39]

Finally, the Provider argues that if the Board does conclude after reviewing all the evidence that Care Well did in fact operate as a SNF, the Whidden TCU would still be eligible for a new provider exemption as a relocated provider. CMS Pub 15-1 §2604.1 provides that ". . . a provider that relocates may be granted new provider status where the normal inpatient population can no longer be expected to be served at the new location." To qualify a provider needs to show that a substantially different patient population is being served and that the total inpatient days at the new location were substantially less than at the old location.

The Provider argues that the patient population served by Care Well and the Whidden TCU are substantially different. Care Well patients had an average length of stay of seven years and Whidden TCU patients had an average stay of 12.5 days. Furthermore, Whidden's TCU treated a patient population with unstable medical conditions that required skilled nursing care seven days a week and skilled rehabilitation services at least five days a week. Those patients, by law, could not have been admitted to a level III facility such as Care Well. In addition, the Provider argues that the total inpatient days at

[38] See Provider's Post Hearing Brief page 64 and Exhibits P-75 and P-76.
[39] See Tr. pp 126-127.

the TCU were substantially less than the days as the Care Well location. The monthly average inpatient days from January through June of 1994 for Care Well was 689 and the average inpatient days per month for the TCU opening in March of 1996 through July 31, 1996 was only 356.6. Therefore, even if the Board finds that the Provider did operate as a SNF in the three years preceding its Medicare certification on March 4, 1996, the Provider asserts that it has met both criteria required to obtain a new provider exemption as a relocated provider.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, the parties' contentions and evidence presented, the Board finds and concludes as follows:

The State of Massachusetts had a moratorium on the licensure and certification of new nursing home beds and construction projects. The Provider obtained operating rights to ICF licensed beds under special "transfer of site" procedures which permit a facility which wishes to open new Level II HBSNF beds to contract with a long term care level III facility to cease operations and "transfer" its "operating rights" to the HBSNF provider. In this case the level III facility (Care Well) located in Malden, Massachusetts closed and the Provider in turn opened a newly constructed level II HBSNF (a.k.a. TCU) in Everett, Massachusetts that had not previously operated. Other than bed rights, the Provider did not obtain any other assets from Care Well. The Provider applied for a new provider exemption but it was denied by CMS because the transfer of the operating rights for the beds was considered a change of ownership, and that Care Well as the previous owner, had operated as a SNF during the three years prior to the transfer.

The Board has previously found that the acquisition of bed rights alone from an unrelated provider through the purchase of a CON or other mechanism used to transfer bed rights does not, in itself, constitute a CHOW, nor does it affect the "new" provider's right to an exemption.[40] The Board finds that CMS' guidelines that impute ownership of an unrelated provider to a provider that purchases a DON or obtains bed rights through other mechanisms are inconsistent with the Medicare regulation at 42 C.F.R. §413.30(e).

This issue has also been addressed in a number of court decisions. In Ashtabula County Medical Center v. Thompson, 191 F.Supp.2nd 884 (N.D. Ohio Feb. 8, 2002) Medicare & Medicaid Guide (CCH) ¶300,964 (Ashtabula), aff'd, 352 F.3d 1090 (6th Cir. 2003), the Court found the Secretary's interpretation of the new provider regulation arbitrary, capricious, and erroneous with respect to the Secretary's position that the acquisition of

[40] See, St. Elizabeth's Medical Center v. BlueCross and BlueShield Association/ Associated Hospital Services of Maine, PRRB Dec. No. 2002-D49, September 30, 2002, Medicare & Medicaid Guide (CCH) ¶80,908, Rev'd., CMS Adm., December 3, 2002, Medicare & Medicaid Guide (CCH) ¶80,951 and more recently, Harborside Healthcare-Reservoir v. BlueCross BlueShield Association/ Empire Medicare Services, PRRB Dec. No. 2006-D14, January 25, 2006, Medicare & Medicaid Guide (CCH) ¶81,462, Rev'd., CMS Adm., March 27, 2006, Medicare & Medicaid Guide (CCH) ¶81,526 and Jordan Hospital v. BlueCross and BlueShield Association/Associated Hospital Services, PRRB Dec. No. 2007-D23, February 28, 2007 Medicare & Medicaid Guide (CCH) ¶81,697, Rev'd., CMS Adm., April 30, 2007, Medicare & Medicaid Guide (CCH) ¶81,724.

bed rights from another provider is a completely different situation from when bed rights are acquired, for example, from a state authority. Under CMS' position, in the first situation the acquisition causes an immediate "lookback" into the services furnished by the relinquishing provider and the potential denial of a new provider exemption. In the second situation, there is no lookback and a new provider exemption is granted.

In *Ashtabula*, the Court's analysis of this matter focused on the intent of the new provider exemption (to allow providers the opportunity to recoup higher costs associated with low occupancy and start-up) vis-a-vis the Secretary's position to "exclude as a class all providers that purchase CON rights from another, unrelated provider that has existed for more than three years from the reaches of the exemption . . . . (CCH) ¶300,964 at 803,405. The Court found the Secretary's arguments, which essentially view state CON moratorium programs as evidence that additional beds are unnecessary for the efficient delivery of needed health care, to be unsupported and little more than conjecture. After consideration of each of the Secretary's arguments the Court states in pertinent part:

> ACMC [Ashtabula County Medical Center] and other providers in moratorium states that purchase CON rights from unrelated providers fit comfortably within the language and purpose of the new provider exemption. The Secretary has advanced no reasonable argument to support a distinction between these providers and other "new providers" deserving of a subsidy to offset high startup costs in the first three years of operation.

Id. at 803,407.

In Maryland General Hospital, Inc. v. Thompson, 308 F.3d 340 (4th Cir. 2002), Medicare & Medicaid Guide (CCH) ¶301,188, the court stated,

> In sum, we conclude that "provider" as used in section 413.30(e) unambiguously refers to the business institution providing the skilled nursing services. It therefore follows that the regulation permits consideration of the institution's past and current ownership, but not the past and current ownership of a particular asset [the CON rights] of that institution. The Secretary's interpretation, however, equates the ownership of an institution providing skilled nursing services with the ownership of a particular asset of that institution. Since there is no language in the regulation that would permit the denial of the exemption because an asset of the new institution was previously owned by an unrelated SNF, the Secretary's interpretation is inconsistent with the plain language of the regulation and cannot be allowed to stand. See *Gardebring v. Jenkins*, 485 U.S. 415, 430 (1988) (explaining that a reviewing court should be "hesitant to substitute an alternative reading for the Secretary's [reading of his own regulation] unless that alternative reading is compelled by the regulation's plain language."); *see* also 5 U.S.C.A. §706(2)(A) (requiring a reviewing court to "set aside agency action, findings, and conclusions" that are "not in accordance with law").

Id. at 804,228.

The Board finds the decisions in the above referenced cases persuasive but notes that the Provider is located in the First Circuit, one of the three circuits that have held the Secretary's interpretation of the regulation permissible. See South Shore Hospital, Inc. v. Thompson, 308 F.3d 91 (1st Cir. 2002), Paragon Health Network v. Thompson, 251 F.3d 1141 (7th Cir. 2001), and Providence Health System v. Thompson, 353 F.3d 661 (9th Cir. 2003). The Board finds that the statute change that had the effect of granting the Provider operating rights directly from the state distinguishes this case from the others in which the Secretary's interpretation has been upheld. For example in South Shore, the First Circuit granted deference to the Secretary's interpretation of the term "provider," as it found that the term, as used in 42 C.F.R. §413.30(e), was "manifestly ambiguous." The Court explained that the precise issue in that case, like the present case, turned on the meanings of "previous ownership," "provider, and "institution," none of which are unambiguous. However in South Shore, the provider did not present factual evidence that a change in the state statute altered the entity from which the Provider received its DON. In the instant case the Board finds that the 1996 change in Massachusetts' statute resulted in a new DON being issued by the state on September 20, 1996 that superseded the DON granted as a result of the transfer of the operating rights for the beds from Care Well. Consequently, there was no "previous owner" of the DON issued September 20, 1996. Accordingly, the South Shore decision, although issued in the First Circuit, is not controlling here.

Additionally, the Board finds that there was no common ownership of the Provider and Care Well; therefore, Care Well cannot be considered a past or present owner of the Provider. However, based upon CMS' position in other cases in which the Board found that a CHOW did not take place and the Board rendered no opinion on the services provided by the previous owner, the Board finds it necessary to expand its decision to cover the issue of previous care rendered.[41]

Massachusetts law distinguishes among long-term care facilities by offering four different levels of licensure which recognize the different types of care needed by different patients: Level I – facilities providing intensive nursing and rehabilitative care, Level II – facilities providing skilled nursing care, Level III – facilities providing supporting routine nursing care and Level IV – facilities proving residential care. Care Well operated as a Level III facility until it closed on October 4, 1995. Whidden TCU is a Medicare-certified SNF or Level II facility.

The controlling case is St. Elizabeth's Medical Center, supra, 396 F.3d 1228 (D.C. Cir 2005). The Administrator has also recognized that CMS is now obligated to utilize the

[41] In Jordan Hospital, the Administrator reversed the Board's decision which ruled only on the CHOW issue, and remanded the decision back to CMS to render a new determination in light of St. Elizabeth. CMS rendered a new determination and the Provider has filed a new appeal with the Board as well as appealed the Administrator's determination to district court.

criteria for determining equivalence set forth in St. Elizabeth's Medical Center. In that case, the Court of Appeals concluded that the Level III Medicaid nursing facility was "primarily engaged in providing custodial care to its residents." In this case, the Intermediary argues that the Provider has failed to meet its burden of proof and has failed to demonstrate by persuasive evidence that Care Well was not providing skilled nursing services – and only providing custodial services.[42] The Board finds, however, that the Provider's burden of proof need not demonstrate that Care Well was providing "only" custodial services, but that Care Well was "primarily engaged" in rendering custodial services and not skilled nursing or rehabilitation services.

The Board finds that the affidavits of Care Well's previous administrators, along with their testimony at hearing and the MMQ documents included in the Intermediary's position paper adequately document that Care Well was not "primarily engaged" in rendering skilled nursing care and related services, but was "primarily engaged" in rendering custodial care to its patients. While the record demonstrates that Care Well occasionally did render skilled services to its patients, those services were not the primary basis for admission to the facility; the primary purpose for the resident's stay was custodial care to assist with the activities of daily living.

The Provider meets the definition of a "new" provider as set forth at 42 C.F.R. §413.30(e) in that it is a licensed and Medicare-certified SNF that has operated as this type of provider for less than three years. The Board's finding that the Provider met the threshold test for entitlement to a new provider exemption should obviate the need to address whether the Provider qualified for an exemption under other criteria, however the Board further found that the previous owner Care Well, did not operate as a SNF in the three years prior to the March 4, 1996 certification date.

DECISION AND ORDER:

ISSUE #1 – Loss on Merger

The Intermediary improperly denied the Provider's loss on merger. The loss as calculated at Exhibit P-64 is accurate. The Intermediary's adjustment is reversed and the issue is remanded to the Intermediary for proper reporting of the loss in the FYE July 31, 1996 cost report.

ISSUE #2 – SNF New Provider Exemption

The Intermediary improperly denied Whidden's TCU a new provider exemption from the routine service cost limits for its hospital-based skilled nursing facility. The Intermediary's determination is reversed.

[42] Intermediary's Post Hearing Brief, pages 6-8.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: July 28, 2009