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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

THIRD APPELLATE DISTRICT

(Sacramento)

BORREGO COMMUNITY HEALTH FOUNDATION, Plaintiff and Appellant, v. STATE DEPARTMENT OF HEALTH CARE SERVICES, Defendant and Respondent.	C083176 (Super. Ct. No. 3420158002245CUWMGDS)

Borrego Community Health Foundation (Borrego) appeals from the denial of a petition for writ of mandate that sought to overturn two audit adjustments the State Department of Health Care Services (Department) made to Borrego's 2008 cost reports. Borrego argues the Department failed to establish by a preponderance of the evidence at the administrative hearing that its audit findings were correctly made. We disagree. The Department established by a preponderance of the evidence that Borrego provided insufficient auditable documentation to support these claimed costs. Borrego also

challenges two legal authorities cited by the administrative law judge (ALJ) as alternative bases for rejecting Borrego's claimed costs: (1) section 104.10 of the Provider Reimbursement Manual (PRM) published by the federal Centers for Medicare & Medicaid Services and (2) *North Clackamas Community Hospital v. Harris* (9th Cir. 1980) 664. F.2d 701 (*North Clackamas*). These collateral arguments cannot overcome the primary defect in Borrego's appeal—the failure to produce sufficient auditable documentation to support its claims. Accordingly, we shall affirm the judgment.

I. BACKGROUND

A. Statutory Background

The Medi-Cal program (Welf. & Inst. Code, § 14000 et seq.) is California's implementation of the federal Medicaid program (42 U.S.C. § 1396 et seq.), through which the federal government provides financial assistance to states so that they may furnish medical care to low-income individuals. (*Robert F. Kennedy Medical Center v. Belshé* (1996) 13 Cal.4th 748, 751 (*Kennedy*).) The Department is the state agency designated to administer the Medi-Cal program. (Welf. & Inst. Code, § 14203.)

"Pursuant to Medi-Cal, participating health care providers, such as hospitals, receive reimbursement directly from the Department for providing medical care to Medi-Cal beneficiaries." (*Simi Valley Adventist Hospital v. Bontá* (2000) 81 Cal.App.4th 346, 348.) Hospitals are reimbursed for their allowable costs determined in accordance with Medicare standards and principles of reimbursement as set forth in the Code of Federal Regulations and the PRM. (*Oroville Hospital v. Department of Health Services* (2006) 146 Cal.App.4th 468, 472; see also Cal. Code Regs., tit. 22, § 51536, subds. (a)(2) & (b)(4).) Generally speaking, to be reimbursable, costs claimed in a cost report "must be based on the reasonable cost of services" and "related to the care of beneficiaries." (42 C.F.R. § 413.9(a).)

"The method by which the Department reimburses Medi-Cal hospital providers is explained in detail in [*Kennedy*]. Briefly stated, Medi-Cal hospital providers receive

interim estimated payments of Medi-Cal reimbursement during each fiscal year, with retroactive adjustments occurring at the end of each fiscal year when actual costs are known. (Cal. Code Regs., tit. 22, § 51536, subds. (c)(2) & (d).) Within four months of the end of each fiscal year, the hospital submits a cost report based on actual costs. (42 C.F.R. § 413.24(f)(2)[].) The Department makes a tentative settlement based on the hospital's unaudited cost report, making additional payments to the hospital if warranted. Following an audit which must be completed within three years (Welf. & Inst. Code, § 14170, subd. (a)(1)), the department issues a final audit report and settlement." (*Little Co. of Mary Hospital v. Belshé* (1997) 53 Cal.App.4th 325, 327, fn. omitted.)

"Consistent with [the] statutory authority [set forth in Welfare and Institutions Code section 14171], the regulations establish detailed appeal procedures applicable to the audit process, including an appeal from a final audit report. (Cal. Code Regs., tit. 22, § 51016 et seq.)" (*Kennedy, supra,* 13 Cal.4th at p. 758.) Medi-Cal providers request a hearing to examine disputed audit findings by submitting a statement of disputed issues to the Department. (Cal. Code Regs., tit. 22, § 51017.)

At the hearing, the Department presents its audit findings and evidence first. (Cal. Code Regs., tit. 22, § 51037, subd. (i).) "The Department has the burden of proof of demonstrating, by a preponderance of the evidence, that the audit findings were correctly made. Once the Department has presented such a prima facie case, the burden of proof shifts to the provider to demonstrate, by a preponderance of the evidence, that the provider's position regarding disputed issues is correct." (*Ibid*.)

B. Factual Background

Borrego is a non-profit, federally qualified health center that provides primary medical care to its patients, some of whom are Medi-Cal beneficiaries. Borrego admits that in 2006, it entered into an agreement to acquire two clinics in Cathedral City and El Cajon, respectively, titled "Agreement for the Purchase and Sale of Assets." Borrego agreed to pay a total purchase price of $3,291,035.50 "from the revenues derived from

the continued operation of the Clinics" in accordance with the terms of a "Non-Recourse Secured Promissory Note." The agreement contained a purchase price allocation that allocated $21,000 of the total sales price to tangible assets "including medical office furniture, fixture, equipment, supplies and inventory," and the remaining $3,270.035.50 to intangible assets "including medical records, employees, computer software, contracts, trade names and trademarks, goodwill and other intangibles." In the event of Borrego's default under the note, Borrego would return the assets and pay any shortfall between what the parties agreed was the seller's previous average monthly gross revenue ($123,708.08 per month) and what it earned after a return of the assets. The agreement included a loan amortization schedule that reflects the principle and interest payments on the clinics based on an interest rate of five percent. The purchase price would be paid over eight years in monthly payments of $41,666.67.

In 2009, Borrego submitted cost reports for the clinics that included line items for "amortization" of medical records and interest paid during the fiscal year ending June 30, 2008.

After an audit, the Department issued reports reclassifying most of these claimed costs as not reimburseable. For the Cathedral City clinic, the Department adjusted Borrego's reported interest expense from $124,747 to $23,394. For the El Cajon clinic, the Department adjusted Borrego's reported interest expense from $61,529 to $19,211. The Department also reclassified as not reimburseable Borrego's claims for amortization of medical records with respect to both clinics.

Borrego submitted a statement of disputed issues with the Department, and a hearing was held before the ALJ on February 27, 2014.

An auditor for the Department testified that she asked Borrego to provide supporting documentation for these claimed costs. Borrego responded by providing her with the sales agreement, promissory note, and a fixed asset and depreciation schedule. The auditor explained that the tangible assets to which $21,000 had been allocated were

not in question. What was missing was specifics about the price of the intangible assets. The fixed asset and depreciation schedule listed the medical records, but there was no information regarding how many medical records were sold, whose medical records they were or the costs associated with maintaining the records. The auditor explained Borrego "never provided a break down or like I requested from the beginning an appraiser or the previous owner's books, something to substantiate these amounts." The auditor also received no information regarding other intangible items listed in the agreement such as employees, computer software, contracts, trade names or trademarks.

Dr. Alfred Ratniewski sold the clinics to Borrego. He has been the Chief Medical Officer for Borrego since the deal closed. When he began negotiating with Borrego about the sale of his clinics, Dr. Ratniewski learned that Borrego was only willing to pay the equivalent of what he had been receiving on a monthly basis as managed care revenue to the clinics. He wanted a ten-year payment period and Borrego wanted a five-year period. Neither party had the value of the clinics appraised.

Borrego's chief executive officer (CEO) testified that he was given strict instructions from his board of directors not to put any money down and that they were not to have any risk involved in the contract. "And I could not pay more than what was going to be added income by the acquisition—in other words, the contract payments from the managed care plans." Borrego acquired the clinics for financial stability. "The only way to do that was by seeing more MediCal patients in MediCal targeted areas. That was the reason for the acquisition."

When asked the basis for the $3.2 million of the purchase price allocated to intangible assets, the CEO testified that the parties arrived at the total sales price by determining the number of years Borrego was willing to pay $41,000 a month. He understood the portion of the payment allocated to intangible assets to represent "[m]edical records, managed care contracts, stuff like that." He could only guess how many medical records had been purchased. The CEO testified that the term "medical

records" is equivalent to the patient, and it would be fair to say Borrego was purchasing a book of business.

An accountant with experience auditing health care facilities and preparing cost reports testified the disputed costs should be deemed allowable because they were related to patient care. He testified that, in his view, the purchase price allocation in the agreement "was kind of a catch-all exhibit" and that the sale was really for a book of business.

C. Procedural Background

On June 18, 2015, the ALJ issued a proposed decision concluding the adjustments were properly made to the claimed costs on the basis that they were not allowable costs. The ALJ also concluded that rather than reclassify the costs as nonreimburseable, they should have been eliminated. The decision explained in pertinent part, "Despite [Borrego's] attempt to frame the purchase of the clinics as a deal to pay approximately $41,000 a month in exchange for entrance into managed care, the terms of the Purchase Agreement are inescapable. In writing, [Borrego] agreed to pay more than $3.2 million plus interest for medical records, goodwill, and other intangible assets. All but $21,000 of the assets purchased in this transaction were described as such. As the Department explained, intangible assets, such as goodwill, are not reimbursable because they are not a service to Medi-Cal beneficiaries. [Borrego] produced no auditable documentation during the audit to define or otherwise allocate the remaining $3,270,035.50 of the purchase price as anything other than an investment that was designed to financially benefit both of the parties to the transaction." The decision also explained that even Borrego's claim that the purchase price was based on the clinics' approximately $41,000 a month in managed care revenue was unsupported by any auditable documentation. "Even if this had been substantiated, it would not have changed the fact that Borrego ultimately agreed to pay $3,270,035.50 plus interest for the intangible assets of two clinics without making any assessment of their market value or otherwise producing

documentation during the audit justifying those costs. [¶] Similarly, even if the vaguely defined $3,270,035.50 portion of this investment was otherwise allowable, the Department was still unable to substantiate the cost basis for depreciating it based on the documentation produced during the audit or the hearing." The ALJ rejected Borrego's argument that the reimbursement principles regarding depreciation set forth in PRM section 104.10 do not apply when the seller is not a cost-reimbursed entity.

The decision separately noted that the adjustments were supported by the decision of the United States Court of Appeals for the Ninth Circuit in *North Clackamas* because the transaction involved the purchase of good will or going concern value.

The ALJ's proposed decision was subsequently adopted as the final decision of the Director of the Department.

Borrego filed a petition for writ of mandate in the superior court pursuant to Code of Civil Procedure section 1094.5 challenging the audit adjustments.

The superior court issued a final ruling and statement of decision denying the petition. The trial court rejected the arguments Borrego raised regarding the alleged inapplicability of PRM section 104.10 and *North Clackamas*. It also explained, "Borrego's bigger problem is the fact that, although the Department did cite [PRM] section 104.10, it is not the only basis for his decision. For example, the Department found that the purchase agreement in this case allocated $3.2 million of the purchase price to intangible assets including 'medical records, employees, computer software, contracts, trade names and trademarks [and] goodwill,' but Borrego produced no auditable documentation otherwise allocating these intangible assets (in other words, Borrego did not establish how much it paid for each category of intangible assets), and some of the intangible assets, like goodwill, are not reimbursable. Moreover, to the extent the $41,000 monthly payments actually represented the transfer of managed care revenue rather than the amortization of the intangible assets listed in the purchase agreement, Borrego 'was unable to substantiate this claim by reference to any auditable

documentation.' Finally, even if Borrego had substantiated this claim, it still failed to demonstrate that the clinics had a fair market value of $3.2 million or a useful life of eight years (which would be necessary in order to substantiate an eight year depreciation period). In other words, Borrego essentially told the department 'trust us, we didn't overpay for the clinics and everything we paid is related to patient care, so you should reimburse us for the entire purchase price.' "

The trial court entered judgment in favor the Department accordingly.

Borrego timely appealed.

II. DISCUSSION

A. *Standard of Review*

The Director's final decision is reviewable under Code of Civil Procedure section 1094.5. (Welf. & Inst. Code, § 14171, subd. (j).) "When reviewing the denial of a petition for writ of administrative mandate under Code of Civil Procedure section 1094.5, we ask whether the public agency committed a prejudicial abuse of discretion. 'Abuse of discretion is established if the [public agency] has not proceeded in the manner required by law, the order or decision is not supported by the findings, or the findings are not supported by the evidence.' " (*County of Kern v. State Dept. of Health Care Services* (2009) 180 Cal.App.4th 1504, 1510.) "Like the trial court, our task is to determine whether the Department's decision is supported by substantial evidence. [Citation.] [¶] 'As to questions of law, appellate courts perform essentially the same function as trial courts in an administrative mandate proceeding, and the trial court's conclusions of law are reviewed de novo.' " (*Hi-Desert Medical Center v. Douglas* (2015) 239 Cal.App.4th 717, 730.)

B. *Failure to Supply Sufficient Auditable Documentation*

To be reimbursable, costs claimed in a cost report "must be based on the reasonable cost of services" and "related to the care of beneficiaries." (42 C.F.R. § 413.9(a).) Borrego argues that the claimed costs met these requirements because they

allowed it to expand and improve care and we must evaluate the reasonableness of the costs against this value. Borrego completely ignores, however, the requirement that Medi-Cal providers maintain and have available for inspection documentation that supports their reimbursement requests. (*Redding Medical Center v. Bontá* (2004) 115 Cal.App.4th 1031, 1039; see 42 C.F.R. § 413.20.) In fact, Borrego argues its written agreement does *not* reflect the terms of the deal. This contention is not ultimately useful to Borrego because "[p]roviders receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors." (42 C.F.R. § 413.24(a).) This auditable cost information must be sufficiently detailed to support the payments. (PRM § 2304.) The evidence at the hearing demonstrated that Borrego failed to produce auditable documentation to justify its costs. This was sufficient to meet the Department's burden and establish the appropriateness of its audit adjustments. We turn now to the collateral issues raised by Borrego.

Generally, Medi-Cal providers may seek reimbursement for capital related costs, including depreciation. (42 C.F.R. § 413.130(a)(1); *Redding Medical Center v. Bontá, supra,* 115 Cal.App.4th at p. 1035.) The allowable depreciation must be "[i]dentifiable and recorded in the provider's accounting records" and "[b]ased on the historical cost of the asset" and its "estimated useful life." (42 C.F.R. § 413.134(a)(1), (2) & (3); see *Redding Medical Center v. Bontá, supra,* at pp. 1035-1036.) The Director's decision explained these principles and also cited to PRM section 104.10 to support the following statements: "When a newly acquired asset is depreciated, the cost basis for depreciation must be the lesser of the historical cost, the acquisition cost to the new owner, or the fair market value at the time of the purchase. ([PRM] § 104.10.) For depreciable assets acquired by providers after December 1, 1997, 'the historical cost of the assets to the acquirer will be the historical cost less depreciation allowed to the owner of record . . . .' ([PRM] § 104.10(E).)"

Borrego offers a series of unavailing attacks on the use of this citation rather than address its larger failure to provide sufficient auditable documentation to support its request.

PRM section 104.10 explains how to calculate "historical cost" for a depreciable asset. As the Director's decision explained, for depreciable assets acquired by providers on or after December 1, 1997, "[t]he historical cost of the asset to the acquirer will be the historical cost less depreciation allowed to the owner of record as of August 5, 1997 (or if an asset did not exist as of August 5, 1997, the first owner of record after August 5, 1997)."[1] (PRM § 104.10(E).)

Borrego argues PRM section 104.10 does not apply because the agreement is "best characterized as an installment agreement to obtain managed care revenue, not a purchase and sale of a depreciable asset." This argument ignores the terms of the purchase agreement which do not allocate any portion of the purchase price to "managed care revenue." It also ignores that Borrego's costs reports specifically sought amortization for medical records and Borrego submitted to the auditor a fixed asset and depreciation schedule listing the medical records.[2] Thus, it was reasonable to assume that PRM section 104.10 was applicable to Borrego's theory for claiming these costs.

Borrego also contends PRM section 104.10 only applies when both parties to the transaction are cost-reimbursed entities. The terms of PRM section 104.10 contain no

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[1] "An asset that was not in existence as of August 5, 1997[,] includes an asset that physically existed but was not owned by a provider participating in the Medicare program as of that date." (PRM § 104.10(E)(1).)

[2] As the trial court noted, the parties appear to have used the terms depreciation and amortization interchangeably. "General accounting usage normally refers to the write-off of tangible assets used in a trade or business as 'depreciation' rather than 'amortization,' which applies to intangibles." (*National Advertising Co. v. County of Monterey* (1970) 1 Cal.3d 875, 884, fn. 6.) The use of both terms may reflect the ultimate confusion regarding what costs Borrego was seeking to depreciate or amortize.

such limitation. Borrego infers that one exists by asserting that "historical cost" can only apply to a cost-reimbursed provider because only they can have "depreciation 'allowed by Medicare.' " We disagree. The fact there is no previous depreciation for the Department to recapture by subtracting from the historical cost does not mean that either the broader concept of historical cost or PRM section 104.10 is inapplicable here.

Moreover, the administrative decision did not rest solely on PRM section 104.10 but rather on Borrego's overall failure to produce adequate auditable documentation to support its claims. As the trial court noted, "Borrego essentially told the department 'trust us, we didn't overpay for the clinics and everything we paid is related to patient care, so you should reimburse us for the entire purchase price.' " This was insufficient. Accordingly, Borrego's appellate claims fail.

C. North Clackamas

The Director's decision also explained that the audit adjustments were supported by the Ninth Circuit's decision in *North Clackamas*, *supra,* 664 F.2d 701. In *North Clackamus*, one hospital purchased another hospital. (*Id*. at p. 702.) An appraiser allocated $440,586 of the $2,674,015 purchase price to "Hospital license and purchased operating value (Going Concern Value)." (*Id*. at p. 703.) The acquiring hospital sought reimbursement for depreciation taken on buildings and for amortization of the going concern value, as well as related interested expenses. (*Ibid*.) The reimbursement for amortization and related interest expenses were disallowed. (*Id*. at pp. 703-704.) The Ninth Circuit affirmed the decision and explained that both going concern value and good will are not reimburseable. (*Id*. at pp. 706-707.) Borrego does not challenge *North Clackamas*'s holding. Rather, Borrego argues *North Clackamas* does not apply because its payments were not for goodwill and do not reflect the going concern value of the clinics. This argument disregards the language of the agreement stating that the purchase price was at least partly allocable to good will. Borrego also argues that in *North Clackamas*, only $440,586 was disallowed and the remaining amount of the sale was

allowed. But in *North Clackamas* an appraiser specifically allocated $440,586 to going concern value. (*Id*. at p. 703.) Here, this specific information was unavailable. Finally, Borrego argues that "[t]his was not a conventional transaction." Borrego's attempts at distinguishing *North Clackamas* are unavailing. Borrego also misses the larger point. Because Borrego provided documentation indicating that part of the claimed costs were for good will and good will is not reimbursable, it was again imperative that Borrego provide auditable documentation to support the allocation of the claimed costs to something that was reimbursable. It did not. And it was Borrego's failure to provide sufficient auditable documentation that renders its appeal without merit.

III. DISPOSITION

The judgment is affirmed. The State Department of Health Care Services shall recover its costs on appeal. (Cal. Rules of Court, rule 8.278(a)(1) & (2).)

/S/

RENNER, J.

We concur:

/S/

RAYE, P. J.

/S/

MAURO, J.