# PROVIDER REIMBURSEMENT REVIEW BOARD
# HEARING DECISION

2002-D6

**PROVIDER** –
Cardinal Cushing Hospital
Goddard Memorial Hospital

Provider No. 22-0156 &
22-0111

**vs.**

**INTERMEDIARY –** Blue Cross and Blue Shield Association/Associated Hospital Services of Maine

**DATE OF HEARING-**
October 25-26, 2000

Cost Reporting Period Ended
September 30, 1994

**CASE NO.** 97-0061
97-0062

**INDEX**

ISSUE:

Was there a recognizable loss upon the transfer of assets to Good Samaritan Medical Center ("Good Samaritan") from Goddard Memorial Hospital ("Goddard") and Cardinal Cushing Hospital ("Cushing") that occurred in connection with the consolidation of the two hospitals and the resulting creation of Good Samaritan Medical Center?

BACKGROUND:

Governing Statues and Regulations:

This dispute arises out of the Intermediary's failure to reimburse depreciation the Providers claim is due under the Medicare program of the Social Security Act 42 U.S.C. §§ 1395 *et seq.,* on a reasonable cost basis for the 1994 cost year. The amounts in contention relate to Providers' claimed loss on the disposal of assets when two hospitals consolidated, resulting in the creation of a new entity.

The Medicare program was established in 1965 under Title XVIII of the Social Security Act (the "Act") to provide health insurance to the aged and disabled. 42 U.S.C. §§ 1395 – 1395cc. The Health Care Financing Administration ("HCFA") (now Centers for Medicare and Medicaid Services ("CMS") is the operating component of the Department of Health and Human Services charged with administering the Medicare program.

The Secretary's 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 the Medicare law and under interpretative guidelines published by CMS. *Id*.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurs during the fiscal year and which proportion of these costs are to be allocated to Medicare. 42 C.F.R. § 413.20. The fiscal intermediary audits the cost reports and determines the total amount of Medicare reimbursement due the provider, which it publishes in a notice of program reimbursement ("NPR"). The NPR sets forth the individual expenses allowed and disallowed by the intermediary. 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 NPR. 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

Under the Medicare statute, a provider is entitled to claim as a reimbursable cost the depreciation (i.e. the loss of value over time) of the building and equipment used to provide health care to Medicare patients. An asset's depreciable value is set initially at its "historical cost," generally equal to the purchase price. 42 C.F.R. § 413.134(a)(2)(b)(1). To determine annual depreciation, the historical cost is then prorated over the asset's estimated useful life in accordance with one of several methods. 42 C.F.R. § 413.134(a)(3). Providers are then reimbursed on an annual basis for a percentage of the yearly depreciation equal to the percentage of the asset used for the care of Medicare patients.

The calculated annual depreciation is only an estimate of the asset's declining value. If an asset is ultimately sold by the provider for less than the depreciated basis calculated under Medicare (equivalent to the "net book value" and equal to the historical cost minus the depreciation previously paid, see 42 C.F.R. § 413.134(b)(9)), then a "loss" has occurred since the sales price was less than the estimated remaining value. In that event, the Secretary assumes that more depreciation has occurred than was originally estimated and accordingly provides additional reimbursement to the provider. Conversely, if the asset is sold for more than its depreciated basis, then a "gain" has occurred and the Secretary takes back or "recaptures" previously paid reimbursement. 42 C.F.R. § 405.415(f)(1). Cushing and Goddard contend that their consolidation into Good Samaritan is a transaction that, like a sale, resulted in a disposition of assets, and gives rise to a loss in which Medicare must share in order to fully reimburse the reasonable costs of providing Medicare services. The Providers allege that the Intermediary's determination denying the loss on disposition of assets in connection with the consolidation of the two facilities was, therefore, incorrect.

Statement of Factual and Procedural History:

Goddard Memorial Hospital and Cardinal Cushing Hospital filed separate cost reports for fiscal year 1994, received separate determinations on those cost reports and filed separate appeals. However, the issue in dispute, and for which additional reimbursement is sought (loss on sale) related to the consolidation of the two entities into a new corporation, affects both facilities. The 1994 cost reports were not filed by the individual Providers, but on behalf of Good Samaritan, the new entity. The Providers in this case have requested a consolidated hearing.[1]

Cardinal Cushing Hospital is a 95-bed, acute care hospital located in Brockton, Massachusetts that was certified for Medicare on January 20, 1968. Goddard Memorial Hospital is a 227-bed, acute care hospital located in Stoughton, Massachusetts that became a Medicare provider on July 1, 1966. The Providers' appeals were timely filed with the Board pursuant to 42 C.F.R. §§ 405.1835-.1841. The Intermediary challenged the Board's jurisdiction in this case.[2] Jurisdiction was addressed by the Board in a separate letter dated July 19, 2002 in which the Board majority ruled that it had jurisdiction.

On October 1, 1993, Cushing and Goddard entered into a Consolidation Agreement.[3] Pursuant to the Consolidation Agreement, a new corporation, Good Samaritan Medical Center, was formed and Goddard and Cushing simultaneously went out of existence. The new Board of Trustees for Good Samaritan consisted of twenty-four members, 12 appointed by Cushing and 12 by Goddard.[4] The new trustees who were specified in the consolidation agreement consisted of 21 members who had been members of the Goddard or Cushing Boards prior to the transaction

[1] See Intermediary's position paper Exhibits I-20 and I-21.

[2] See Tr., Vol 1, p.7, L. 9.

[3] See Providers' Supplemental position paper Exhibit A.

[4] See Tr., Vol. I, pp. 67-68.

and three community representatives who had not been members of either Board.[5] The new entity acquired the assets of Cushing in exchange for the assumption of Cushing's debts and liabilities and simultaneously acquired the assets of Goddard in exchange for the assumption of Goddard's debts and liabilities. The total of the debts and liabilities assumed by Good Samaritan was $83,075,459.[6] Prior to the consolidation, the book value of Cushing's total property, plant and equipment, net of depreciation, was $15,990,554. After the consolidation, Cushing allocated a portion of the liabilities assumed for those assets, resulting in a claimed revaluation of $12,105,812.[7] Thus, Cushing claims it incurred a loss of $3,884,742 on the disposition of its assets to Good Samaritan. Prior to the consolidation, the book value of Goddard's total property, plant and equipment, net of depreciation, was $23,081,891. After the consolidation, Goddard allocated a portion of the liabilities assumed for these assets, resulting in a claimed revaluation of $15,566,664.[8] Thus, Goddard claimed it incurred a loss of $7,515,227 on the disposition of its assets to Good Samaritan.

In filing their fiscal year 1994 cost reports, the Providers requested that they be allowed to recognize as allowable costs the losses they claimed they each incurred on the disposal of their assets to Good Samaritan in connection with the consolidation.[9] Specifically, Goddard claimed a reimbursement of $2,725,225 for the previously unrecognized depreciation of its assets, and Cushing claimed a reimbursement of $880,614 for the previously unrecognized depreciation of its assets.

Blue Cross and Blue Shield Association/Associated Hospital Services of Maine ("Intermediary") reviewed Cushing's request and, by letter dated April 30, 1996, denied it, asserting that "the consolidation was between related parties . . . since the members of the Boards of Directors for both [Cushing and Goddard] before the consolidation were essentially the same as the members of the Board of Trustees for the Good Samaritan Medical Center after the consolidation."[10]

The Providers were represented by Carolyn Jacoby Gabbay, Esquire, of Hutchins, Wheeler & Dittmar. The Intermediary was represented by Eileen Bradley, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDERS' CONTENTIONS:

The Providers contend the transaction that occurred between Goddard and Cushing was a

[5] See Providers' Supplemental position paper Exhibit A.

[6] See Providers' Supplemental position paper Exhibits B & C.

[7] See Providers' Supplemental position paper Exhibit B.

[8] See Providers' Supplemental position paper Exhibit C.

[9] When a loss (or gain) on sale or disposal is recognized, the depreciable basis of the underlying assets is adjusted accordingly so that going forward there is no overpayment (or underpayment) for those assets. There is, therefore, no windfall or duplicative payment to the successor owner when a loss is recognized.

[10] See Providers' Supplemental position paper Exhibit G.

consolidation that gives rise to a recognition of a loss on disposal of assets under the relevant HCFA regulations. In 1977, HCFA published a proposed regulation to address the reimbursement effect of statutory mergers and consolidation. That proposed regulation provided that all consolidations should be treated as between related parties and that, therefore, no recognition of gains or losses would be allowed. If the 1977 proposed regulation had become final, the Goddard-Cushing transaction would not have been eligible for a revaluation and there could have been no request for reimbursement. In 1979, however, in response to comments that had been received concerning the proposed regulation, HCFA reversed its policy and promulgated a final version of the 1977 proposed regulation that explicitly recognized that consolidations could occur between unrelated parties. The Provider contends that, when such a consolidation occurred, the regulation allowed a recognition of any resulting gains or losses.

The new regulation, which was subsequently published at 42 C.F.R. § 413.134(l)(3), states that "[i]f the consolidation is between two or more corporations that are unrelated (as specified in § 413.17), the assets of the provider corporation(s) may be revalued in accordance with paragraph (g) of this section."

The new regulation was incorporated in the 1986 draft of the change of ownership section of the Medicare Intermediary Manual[11] at § 4502.7, which sets out HCFA's position in greater detail:

> A consolidation is similar to a statutory merger, except that a new corporation is created. Medicare program policy permits a revaluation of assets affected by corporate consolidations between unrelated parties.
>
> EXAMPLE: Corporation A, the provider, and Corporation B (a non-provider) combine to form Corporation C, a new corporate provider entity. By law, Corporations A and B cease to exist. Corporations A and B were unrelated parties prior to the consolidation . . . .
>
> The RO (regional office) determines that the consolidation constitutes a CHOW [change of ownership] for Medicare certification purposes . . . . A gain/loss to the seller (Corporation A) and a revaluation of assets to the new provider (Corporation C) are computed.

In 1994, one of the Providers' witnesses, a former high-ranking HCFA official who was then working as a consultant for Coopers & Lybrand, was hired by Good Samaritan to assess the reimbursement consequences of the Cushing-Goddard transaction. On June 6, 1994, this witness wrote a letter to HCFA asking for guidance on the reimbursement consequences of the following transaction:

> Hospital A and Hospital B will merge to form Hospital C.
> Hospital C will acquire the assets of each organization in exchange

[11] See Providers' Supplemental position paper Exhibit F.

> for the assumption of all liabilities of each organization. Hospitals A and B will cease to exist concurrent with the consolidation and formation of Hospital C.[12]

In its letter response, HCFA stated that the transaction described "appears to be a consolidation as defined in 42 C.F.R. § 413.134(k)(3) requiring a determination of gain or loss under 42 C.F.R. § 413.134(f)." Id. The Providers claim that the transaction described in that letter describes exactly the Goddard-Cushing transaction.

The Providers acknowledge that although the regulation that was finally adopted in 1979 recognized that a consolidation could give rise to a revaluation of assets, it provided that it would do so only if the consolidation took place between "unrelated parties." See 42 C.F.R. §§ 413.134(l)(3)(i); 413.134(f); 413.134(g). The Providers argue that, as expressly contemplated by the regulation, "the consolidation [was] between" Cushing and Goddard. See 42 C.F.R. § 413.134(1)(3)(i). They were the competitors who entered into the Consolidation Agreement. They are, therefore, the only parties who are relevant to the related party analysis.[13] The Providers assert that there is no evidence that prior to the transaction Cushing and Goddard were in any way related to one another within the meaning of 42 C.F.R. § 413.17; and that the Intermediary's witnesses conceded that there was no such relationship.[14] The Providers point to evidence that prior to October 1, 1993, Cushing and Goddard had no board members in common or any other indicia of relatedness. They were never under common ownership and were never associated or affiliated with each other. Neither hospital ever had the power to control the other. To the contrary, the Consolidation Agreement was entered into only after many months of arms-length negotiation and compromise. Negotiations broke down over governance issues and had to be revived by the intervention of physicians in the community.[15] Neither party had the ability to force a deal. In sum, the Providers contend that there was no "common ownership or control" between Goddard and Cushing at any time prior to the consolidation.

The Providers note that the Intermediary here has denied Cushing and Goddard's requests for reimbursement on the grounds, not that they were related to one another at the time the transaction occurred, but that each of them was related to Good Samaritan after the consolidation was completed. The Intermediary bases that conclusion on the fact that a significant number of the members of Good Samaritan's Board of Trustees were individuals who had been members of the Boards of Cushing and Goddard.[16] The Providers insist that the logic proposed by the Fiscal

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[12] See Providers' Supplemental position paper Exhibit H.

[13] The Providers note the Fiscal Intermediary argument that, when reading 42 C.F.R. § 413.134(1)(3)(i), one should substitute the word "among" for the word "between." The Provider contend that even if the word "among" were used, that would not imply that one should include the entity resulting from a consolidation in the analysis of whether the parties to the transaction were related. Furthermore, had the drafters intended to use the word "among," they would have.

[14] See Tr., Vol. II, p. 109.

[15] See Tr., Vol. I, pp. 62-63, 66.

[16] See Intermediary's position paper, p. 31.

Intermediary would render 42 C.F.R. § 413.134(1)(3)(i) utterly meaningless, because in virtually every consolidation the resulting organization could be said to be, in one way or another, "related to" organizations which consolidated. Therefore, under the Fiscal Intermediary's interpretation, there would never be a "consolidation between unrelated parties" pursuant to § 413.134(1)(3)(i). The Providers contend that the focus of the related party inquiry must be on the original parties to the transaction (i.e., Cushing and Goddard) and not the resulting organization (i.e., Good Samaritan). They cite Northwest Comm. Hosp. v. Califano, 442 F. Supp. 949, 951 (S.D. Iowa 1977) ("Northwest") ("the relationship between the parties must be determined by the circumstances existing at the time the . . . contract was executed, not according to the rights created under the contract.") (emphasis added) and Manor Health Care Corp. v. Pennsylvania, 1100 C.D. 1987, (Pa. Commw. Ct. 1988), (1989-2 Transfer Binder) Medicare and Medicaid Guide (CCH) ¶ 37,980 (holding that two hospitals were not related because, at the time of the purchase of the entity in question, the purchaser and seller were unrelated).

The Providers further rely on Buckingham Valley Nursing Center v. Aetna Life and Casualty Company, PRRB Hearing Dec. No. 90-D13, Jan. 30, 1990, (1991 Transfer Binder) Medicare and Medicaid Guide (CCH) ¶ 38,369, aff'd. HCFA Admin., March 28, 1990, Medicare and Medicaid Guide (CCH) ¶ 38,459, aff'd, sub nom Nursing Center of Buckingham and Hampden, Inc. v. Shalala, 990 F.2d 645 (D.C. Cir. 1993)[17] ("Buckingham"), in which the Board concluded that the relationship between the parties in a one-time purchase transaction must be determined at the time of the execution of an agreement, not after the transaction is consummated. Providers argue that although Buckingham involved a gain on sale allowing Medicare to recover excess depreciation, its holding is no less applicable to a claimed loss on sale and it cannot refuse to reimburse for underdepreciation.

The Providers cite Sid Peterson Memorial Hospital v. Blue Cross and Blue Shield, PRRB Dec. No. 99-D24, Feb. 23, 1999,[18] Medicare and Medicaid Guide (CCH) ¶ 80,161 at 200,670. ("Sid Peterson") wherein this Board identified the means through which control may be exercised: "(1) authoritative positions held by an individual in both entities; (2) authoritative positions and/or equity interests of a group of individuals or an equity held in both parties; or (3) a contract between two entities that grants one party significant control over the other." The Providers insist that there is no question that, prior to the consolidation, none of those elements were applicable to the Cushing and Goddard consolidation. There was no person, no interest and no contract through which control could have been exercised and there was no common ownership.

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[17] The Board ruled that the Buckingham agreement to purchase a nursing home in Pennsylvania was not an enforceable agreement within the meaning of the Deficit Reduction Act of 1984 ("DEFRA"). The Secretary affirmed the Board's decision. On appeal, the district court granted summary judgment, affirming the Secretary's decision to affirm. On review, the Circuit Court affirmed the district court's judgment.

[18] The Providers argue that while Sid Peterson provides a succinct statement of the factors which demonstrate control, its facts are not analogous to the case at hand, as it involved the sale of a hospital from a foundation to a non-profit corporation created by the foundation. They argue that, hence, the finding of control in that case provides no guidance here.

The Providers also direct us to North Iowa Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 00-D52, May 5, 2000,[19] (2000 Transfer Binder) Medicare and Medicaid Guide ¶ 80,442. There the intermediary claimed that a provider was related to the hospital formed out of its consolidation with another provider because four members of its 20 member Board of Trustees were appointed two weeks after the consolidation to the 18 member board of the hospital created as a result of the consolidation. The Board concluded that "the element of control over [the consolidated hospitals'] actions or policies after the merger has little or no relevancy to the case." Id. The Board noted that both the purchase price and the terms of the purchase agreement had been fixed before the members of the provider's board were appointed to the board of the consolidated entity and therefore before they had any opportunity to exercise any control over the new provider. The Providers point out that, here, the details of the consolidation agreement were agreed upon before any members of either the Cushing or Goddard Board were members of the Good Samaritan Board, and their ability to affect Good Samaritan's actions or policies after the consolidation similarly has "little or no relevancy to the case."[20]

The Providers assert the Intermediary's position is also inconsistent with HCFA's own understanding of the meaning of relatedness in this and similar contexts prior to 1996. The Providers argue that the Intermediary's position rests almost entirely on a novel concept called "continuity of control."[21] "Continuity of control," as that phrase is used by HCFA, was intended to mean that parties who are clearly unrelated both prior to a transaction and at the time the transaction takes place can nonetheless be held to be related based on relationships arising out of the transaction itself. In other words, HCFA is allowed to look at the relationship of the parties after the transaction to determine whether or not they are related. The Providers assert that "continuity of control," as an element of an intermediary's analysis, did not exist within HCFA until 1996.

The Providers' witness, a certified public accountant with twenty years of experience in Medicare reimbursement matters, testified that he reviewed relevant manuals, regulations and other documents promulgated by HCFA prior to 1996 and was not able to find even a single reference to "continuity of control" or a single instance of its application.[22] The Providers assert

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[19] See Providers' Supplemental position paper Exhibit 10.

[20] The HCFA administrator reversed the Board's decision, because he found that the "totality" of circumstances established a relatedness between the provider and the new, consolidated entity. North Iowa Medical Center v. Blue Cross and Blue Shield, Decision of the Administrator on Review of the PRRB Decision No. 2000-D52, May 2, 2000, (2000-1 Transfer Binder) Medicare and Medicaid Guide (CCH) ¶ 80,442, rev'd HCFA Admin. July 7, 2000, (2000-1 Transfer Binder ) Medicare and Medicaid Guide (CCH) ¶ 80,519. Those circumstances included, in addition to the four trustees, a commonality of ownership and some carryover of administrative personnel. Providers argue that it is by no means clear that the Administrator would have reversed simply as a result of the common trustees. However, the U. S. D. C., Northern District Court of Iowa found that the parties to the transaction were not related through ownership and control as found by the HCFA administrator and therefore, reversed the Administrator's decision, 196 F .2d 784 (N.D. Iowa 2002) appeal docketed (8th Cir. June 2002).

[21] See Tr., Vol. II, pp. 18-19, 109.

[22] See Tr., Vol. I, pp. 175, 177.

that applying a 1996 concept to a transaction that took place in 1993 is an exercise in result-oriented retroactive rulemaking of the kind that is forbidden by Bowen v. Georgetown University Hosp., 488 U.S. 204 (1988).

Another witness on behalf of the Providers was the former Director of Provider Audit for HCFA, who was also in charge of the taskforce within HCFA that compiled the change of ownership manual.[23] He testified that the framers of that regulation were aware that it would be virtually impossible for there to be a consolidation in which, after the consolidation was consummated, at least some board members of the formerly separate organizations would not serve on the board of the new entity. However, that did not prevent HCFA's taskforce members from concluding that a consolidation between previously unrelated parties was a genuine change of ownership that should give rise to a recognition of gain or loss.[24] He also stated that the concept of "continuity of control" was unknown within HCFA prior to 1996.[25]

Another of the Providers' witnesses testified that, in all of the numerous consolidations he had been involved in or been aware of, there has always been some carryover of members of the governing board or management personnel from the consolidating institutions to the newly created one.[26] He explained that such carryover provides a measure of stability that is essential for bondholders and creditors who must authorize the transaction and the new institution's relationships with its medical staff, its non-medical personnel, and the community at large.[27] The Providers' witness testified that those considerations were the principal reason for trustees in the Goddard-Cushing transaction becoming trustees of Good Samaritan.[28] He asserted that even if it were possible to create a new institution with no infusion of personnel from the consolidating entities, such a complete break with the past would have deleterious and unacceptable effects on the quality of patient care, the conduct of the new institution's business and its position within the community.[29] Invoking "continuity of control" to deny reimbursement in the circumstances of this case, therefore, would effectively mean that there could never be a recognition of gain or loss in the context of a consolidation, despite the explicit authorization for such recognition contained in the 1979 regulation.

On October 19, 2000, HCFA published a Program Memorandum which it labeled a "clarification" of the application of the regulations at 42 C.F.R. § 413.134 to mergers and consolidations.[30] That

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[23] See Providers' Supplemental Exhibit F and Tr., Vol. I, pp. 223, 226.

[24] See Tr., Vol. I, p. 235.

[25] See Tr., Vol. I, pp. 248, 251.

[26] See Tr., Vol. I., p. 183.

[27] See Tr., Vol. I, pp. 183-186.

[28] See Tr., Vol. I., pp. 67-68.

[29] See Tr., Vol. I, pp. 183-186.

[30] See Intermediary's position paper Exhibit 55.

memorandum discusses "continuity of control" and the Agency's position that the regulations at 42 C.F.R. § 413.134 were only meant to address for-profit mergers and consolidations. It states that "special consideration" must be taken into account when applying those regulations to not-for-profits. The Providers assert that the practical effect of the memorandum would be to make it impossible for consolidating not-for-profits to qualify for reimbursement and that the Oct. 2000 memo is in direct conflict with earlier interpretations. The Provider cites evidence that on May 11, 1987, the Director of the Division of Reporting and Payment Policy responded to an inquiry from an attorney for two consolidating non-profits by stating that "[m]ergers and consolidations of nonstock, nonprofit providers may give rise to revaluations of assets," and that "[n]otwithstanding the reference to 'capital stock' in the regulations section of 42 C.F.R. § 413.134(k) . . . we look to that regulation for authority in addressing mergers and consolidations of nonstock issuing corporations because the principles involved would be the same."[31] Similarly, HCFA, when responding to the witness's letter in August, 1994, did not take note of any difference in treatment between profits and non-profits, although the witness had plainly stated that the institutions involved were non-profits.[32] Two witnesses for the Providers testified that, based on their many years of dealing with reimbursement matters inside and outside of HCFA, the policy enunciated in the Intermediary's position paper[33] concerning profit and non-profits has not been HCFA policy up to now.[34]

The Intermediary also asserts that the consolidation was not a bona fide transaction because (1) the fair market value of the hospitals' assets was not determined, and (2) no new consideration was advanced by Good Samaritan. The Providers counter that the consolidation of Cushing and Goddard was an arm's length transaction which resulted in a complete transfer of all of their assets to Good Samaritan for valuable consideration – i.e., the assumption of their debts and liabilities. They contend the transaction meets the definition of a bona fide sale as defined in Black's Law Dictionary p. 177 (6th ed.), (A bona fide sale is a "completed transaction in which seller makes sale in good faith, for valuable consideration without notice of any reason against the sale") quoted in Ashland Regional Medical Center v. Blue Cross and Blue Shield Assoc., PRRB Dec. No. 98-D32, Feb. 27, 1998, Medicare and Medicaid Guide (CCH) ¶ 46,109 ("Ashland") and Lac Qui Parle Hospital of Madison, Inc. v. Blue Cross and Blue Shield Assoc., PRRB Dec. No. 95-D37, May 10, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,269 ("Lac Qui Parle").[35]

The Providers point out that the Board has expressly held that the assumption of liabilities is valid consideration for assets purchased and is equivalent to the "purchase price" of the transaction. See Lac Qui Parle (holding that cash plus assumed liabilities equaled the purchase price, and that a bona fide sale occurred which resulted in a recognizable loss on depreciable

[31] See Providers' Supplemental position paper Exhibit D.

[32] See Intermediary's position paper Exhibits 4 and 5.

[33] See Intermediary's position paper Exhibit 55.

[34] See Tr., Vol. I, p. 176, 251.

[35] See Providers' Supplemental Exhibits P-7, P-8.

assets where the purchaser paid a total of $330,000 in cash and assumed liabilities in exchange for assets "worth" $1,114,000). The Providers also notes that the 1987 HCFA letter states "[i]n a situation where the surviving/new corporation assumes liability for outstanding debt of the merged/consolidated corporation, the assumed debt would be viewed as consideration given."[36]

The Intermediary points to the lack of evidence that fair market value was paid, but the Providers counter that there is likewise no evidence that Good Samaritan paid anything other than the fair market value for the hospitals' assets. The regulations define fair market value to be "the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition." 42 C.F.R. § 413.134(b)(2). The Providers note that the Medicare program routinely respects the price and terms reached in arm's length negotiations. For example, in cases where the Secretary has defended against claims by providers for under-depreciation (losses), the Secretary has routinely relied solely on the purchase price of the asset when determining the amount of depreciation. See, e.g., Vallejo General Hosp. v. Bowen, 851 F.2d 229 (9th Cir. 1988) ("Vallejo")[37] (upholding Secretary's reliance on allocation of purchase price set forth in purchase agreement and the Secretary's rejection of a provider-commissioned appraisal used as the basis of the allocation submitted on the provider's cost report). The Vallejo court stated:

> The Secretary has adequately explained why additional documentation . . . is not required. A bona fide sale bargained for at arm's length can be expected to produce allocations, which accurately reflect the true economic value for an asset . . . . [T]he sales price agreed to by the parties is the real market value. [The Secretary] explained that it is in the interest of both parties bargaining rationally at arm's length to evaluate accurately the property increments.

Id. at 232 (emphasis added).

The Providers argue that the Medicare regulations only require that a provider obtain a fair price for an asset. A provider need not solicit bids when purchasing supplies and seeking recognition of those costs. Similarly, when selling assets, the provider must merely seek out a fair price for the asset, viewed in light of all the terms under which the transaction is structured. In addition, the Medicare regulations do not require that parties "shop" their transaction, engage in a bid process, or conduct an auction in order to establish an asset price.[38]

The Providers assert that the Medicare regulations do not require the parties to have their assets appraised to establish fair market value. The Providers' expert witness stated that when he was in charge of provider audit at HCFA and directing intermediaries in the field, it was his view that

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[36] Providers' Supplemental Exhibit D.

[37] See Providers' Supplemental Exhibit P-10.

[38] The Providers argue that Goddard did conduct serious discussions with another arms-length party (*i.e.*, Brockton Hospital) about a possible transaction prior to commencing negotiations with Cushing so that even if there were such a requirement, it was satisfied here.

appraisals served little or no purpose in a consolidation situation and were, in fact, an "exercise in futility."[39] The Intermediary stated that, even if the information and numbers that Cushing and Goddard provided to support their claim for reimbursement had been supported by an appraisal, they would still have felt the need to audit them.[40] The Providers assert that the Medicare program's regulations are proscriptive on the use of appraisals and generally seek to limit the occasions on which appraisals may be offered to situations in which actual data is not available from which to determine historical or fair market value, see HCFA Pub. 15-1 § 104.10, and that Fiscal Intermediaries and the Secretary regularly reject the use of appraisals which differ from the purchase price, or the allocation thereof, agreed upon by the parties in the purchase agreement. See Vallejo; Peninsula Medical Center v. Blue Cross and Blue Shield of Florida, PRRB Dec. No. 94-D62 July 29, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,614; Care Plus, Inc. Group Appeal v. Aetna Life Ins. Co, PRRB Dec. No. 96-D6, Jan. 29, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,010. In Ashland, where the fiscal intermediary's appraisal valued the hospital at $2,400,000, the PRRB instead used the parties negotiated purchase price paid.

The Providers contend that in direct contravention of the opinion of HCFA, the Intermediary also argues that there is no authority for recognizing a loss on consolidation.[41] The Providers label this argument as specious. It is based on the fact that 42 C.F.R. § 413.134(1)(3)(i) (the consolidation between unrelated parties provision) does not include a specific reference to 42 C.F.R. § 413.134(f)(2) (the gain or loss on sale or disposal provision). Nevertheless, 42 C.F.R. § 413.134(1)(3)(i) states: "[i]f the consolidation is between two or more corporations which are unrelated (as specified in § 413.17), the assets of the provider corporations(s) may be revalued in accordance with paragraph (g) of this section." Paragraph (g), in turn, requires that the provider's assets be revalued so that the historical cost does not exceed the lowest of (1) the allowable acquisition cost of the prior owner, (2) the acquisition cost of the new owner, or (3) the fair market value. See 42 C.F.R. § 413.134(g). If a provider's assets are revalued in accordance with paragraph (g) -- as providers assert they must be -- any resulting gain or loss must, in turn, be determined. Providers point out that, surely, if the required revaluation had resulted in a gain on sale, the intermediary would recapture the excess depreciation taken by the provider. Accordingly, where, as here, a loss on sale results from a consolidation between unrelated parties, the assets must be revalued in accordance with paragraph (g), and the undepreciated basis of the assets must be determined in accordance with paragraph (f) and reimbursed as an allowable cost by the Intermediary. In sum, the "gain or loss on sale or disposal" provision itself expressly states, "if disposal of a depreciable asset . . . results in a gain or loss, an adjustment is necessary in the provider's allowable cost." The mere fact that there is no specific reference to this provision in § 413.134(l)(3)(i) does not mean that a provider, or the intermediary, may ignore the provision's mandate. The provision at issue (relating to consolidations between

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[39] See Tr., Vol. I, p. 238

[40] See Tr., Vol. II, pp. 44-45.

[41] As discussed above, HCFA has stated that consolidations between unrelated parties require that any resulting gain or loss be determined. See Exhibit H (letter from Charles R. Booth of HCFA finding that the type of transaction at issue "appears to be a consolidation as defined in § 413.134(l)(3)(i) requiring a determination of gain or loss under § 413.134(f).").

unrelated parties) is part of a chapter devoted to and entitled "Depreciation: Allowance for Depreciation Based On Asset Costs." A specific reference to paragraph (f) (the "gain or loss on sale or disposal" provision) is, therefore, hardly necessary, as that provision is central to the chapter and the statutory scheme with which this case is concerned.

In sum, the Providers believe that none of the Intermediary's arguments justify disallowing the hospitals' requests that the losses they each incurred on the sale of their respective assets to Good Samaritan be recognized. They contend that, consequently, Cushing is entitled to reimbursement for the resulting $880,614 in underdepreciation on its assets sold to Good Samaritan, and Goddard is entitled to reimbursement for the resulting $2,725,225 in underdepreciation on its assets sold to Good Samaritan.

INTERMEDIARY'S CONTENTIONS:

The Intermediary cites the Medicare depreciation regulation at 42 C.F.R. § 413.134,[42] which provides for an adjustment to depreciation, in the form of a gain or loss, upon disposition of assets under certain defined and limited circumstances:

> (f) Gains and losses on disposal of assets. -- (1) General. Depreciable assets may be disposed of through sale, scrapping, trade-in, exchange, demolition, abandonment, condemnation, fire, theft, or other casualty. If disposal of a depreciable asset, including the sale or scrapping of an asset before December 1, 1997, results in a gain or loss, an adjustment is necessary in the provider's allowable cost. (No gain or loss is recognized on either the sale or the scrapping of an asset that occurs on or after December 1, 1997.) The amount of a gain included in the determination of allowable cost is limited to the amount of depreciation previously included in Medicare allowable costs. The amount of a loss to be included is limited to the undepreciated basis of the asset permitted under the program. The treatment of the gain or loss depends upon the manner of disposition of the asset, as specified in paragraphs (f)(2) through (6) of this section.

See also HCFA Pub. 15-1 § 130.

The Intermediary insists that none of the above instances in the list of "dispositions" includes a merger or consolidation, leading to the preliminary conclusion that no loss may be claimed upon the occurrence of either of those events. The Medicare program has specifically defined and limited the circumstances under which it will recognize that a provider has "disposed of" an asset. Therefore, even if a provider could prove that other transactions under generally accepted accounting principles qualify as "sales" or "dispositions," that would not require Medicare's recognition of any gain or loss arising therefrom. Shalala v. Guernsey Memorial Hospital, 115 U.S. 1232 (1995).

[42] See Intermediary's position paper Exhibit I-26.

Nevertheless, a subsequent subsection of the depreciation regulations does grant providers the ability to claim subsection (f) losses upon mergers (but not for consolidations) under the general heading of "Transactions involving provider's capital stock." It states:

> (l) Transactions involving provider's capital stock. -- (1) Acquisition of capital stock of a provider. If the capital stock of a provider is acquired, the provider's assets may not be revalued. For example, if Corporation A purchases the capital stock of Corporation B, the provider, Corporation B continues to be the provider after the purchase and Corporation A is merely the stockholder. Corporation B's assets may not be revalued.
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> (2) Statutory merger. A statutory merger is a combination of two or more corporations under the corporation laws of the State, with one of the corporations surviving. The surviving corporation acquires the assets and liabilities of the merged corporation(s) by operation of State law. The effect of a statutory merger upon Medicare reimbursement is as follows:
>
> *(i)* Statutory merger between unrelated parties. If the statutory merger is between two or more corporations which 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 basis of the assets owned by the surviving corporation is unaffected by the transaction. An example of this type of transaction is one in which Corporation A, a nonprovider, and Corporation B, the provider, are combined by a statutory merger, with Corporation A being the surviving corporation. In such a case the assets of Corporation B acquired by Corporation A may be revalued in accordance with paragraph (g) of this section.
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> (ii) Statutory merger between related parties. If the statutory merger is between two or more related corporations (as specified in § 413.17), no revaluation of assets is permitted for those assets acquired by the surviving corporation. An example of this type of transaction is one in which Corporation A purchases the capital stock of Corporation B, the provider. Immediately after the acquisition of the capital stock of Corporation B, there is a statutory merger of Corporation B and Corporation A, with Corporation A being the surviving corporation. Under these circumstances, at the time of the merger the transaction is one between related parties and is not a basis for revaluation of the provider's assets.
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> (3) Consolidation. A consolidation is the combination of two or more corporations resulting in the creation of a new corporate entity. If at least one of the original corporations is a provider, the effect of a consolidation upon Medicare reimbursement for the provider is as follows:

> (i) Consolidation between unrelated parties. If the consolidation is between two or more corporations which are unrelated (as specified in § 413.17), the assets of the provider corporation(s) may be revalued in accordance with paragraph (g) of this section.
>
> (ii) Consolidation between related parties. If the consolidation is between two or more related corporations (as specified in § 413.17), no revaluation of provider assets is permitted.[43]

Thus, although the ability to revalue assets under subsection (g) is offered in the regulations dealing with consolidation, there is no provision for a subsection (f) gain or loss on consolidation. The Intermediary argues that, under general rules of statutory construction, the fact that there is specific language in 42 C.F.R. § 413.134(1)(2) subjecting mergers between unrelated parties to the gain or loss provisions of subsection (f), but no such language in 42 C.F.R. § 413.134(1)(3)(i) for consolidations between unrelated parties, is conclusive evidence that the gain and loss provisions were not intended to be applied to consolidations.

The Intermediary contends that because a "sale" is separately defined from a "consolidation," there can be no doubt that they are considered separate events under the Medicare program. That is, where the definition of "consolidation" is met, the transaction is perforce not a "sale." In their position papers, the Providers admit that their transaction was a consolidation, yet they incorrectly assume that a loss on consolidation may be recognized under Medicare as a "sale."[44] Because the Providers only reference the same regulations discussed above, regulations which do not offer that benefit, the conclusion is inescapable that there is no authority for recognizing a loss on consolidation.

The Intermediary argues that, assuming that consolidations are "sales" or that consolidations otherwise can give rise to recognizable losses, no losses should be recognized in this case because the transaction was "between two or more related corporations." (as specified in § 413.17).[45]

Under 42 C.F.R. § 413.17, parties are related for Medicare purposes when there is either "common ownership" or "control." The operative word in either instance is "significant." Under 42 C.F.R. § 413.17(b)(2), common ownership exists when an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

Similarly, under 42 C.F.R. § 413.17(b)(3):

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[43] See Intermediary's position paper Exhibit I-26.

[44] See Intermediary's position paper Exhibits I- 20 and I-21 at 6.

[45] See Intermediary's position paper Exhibit I-24.

> Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

The Intermediary points out that Chapter 10 of HCFA Pub. 15-1 is devoted to clarifications of the related party rules. While many of the sections simply parrot the regulatory language, others further explain and develop the concepts in the regulations.[46] Even so, because the regulations use a relative value word "significant," to separate the related from the non-related, the instructions recognize that each determination is largely a fact-specific one. HCFA Pub. 15-1, § 1004.3.[47]

The Intermediary contends that, in this case, the most compelling evidence on the question of relationship is the composition of the Board of Trustees of the three corporations just before and just after the consolidation.[48] Of the 24 members of the Board of the new corporation, 12 were appointed by Cushing and 12 by Goddard. Cushing and Goddard even appointed the chairman and vice-chairman of the new organization, not content to leave that election to the trustees of the new board. Thus, 87.5% of the brand new Board was controlled by Cushing and Goddard, and by any definition, that is "significant" ownership and control. Moreover, even more than two years later, in August, 1995, when the new Board consisted of 25 trustees, 21 of them (80%) were trustees of Cushing or Goddard on September 30, 1993. The Intermediary notes that we have the luxury in this matter of knowing that both the regional and central offices of HCFA agree with this conclusion for those very reasons.[49] The central office noted a "continuity of control" from the two Providers before the transaction to the single provider thereafter.[50]

The Intermediary argues that the Sid Peterson decision[51] is similarly of no assistance to the Providers. In that case, a foundation owned a hospital, set up a new corporation formed with significant membership from the foundation, then transferred the hospital to the new corporation, called SPMH. The Provider asked the Board to focus on the transaction and post-transaction events and find that the transaction was not between related parties. The intermediary made arguments very similar to those the Intermediary is making in this case, that "it is necessary to look at the entire transaction from beginning to end ……" In Sid Peterson, the Board looked at the "consummation" of the agreement, the "implementation" of the agreement, and the "continuation of substantial control" after the agreement. Even though the Board found that the parties were related at the time of the transaction, the Board did so by reviewing the "continuum of events." The Intermediary believes that a decision finding related parties at the time of the

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[46] See Intermediary's position paper Exhibit I-32.

[47] See Intermediary's position paper Exhibit I-32.

[48] See Providers' Exhibit P-A at § 3 and Exhibit 1 thereto at 1-2, and Intermediary's position paper Exhibit I-10.

[49] See Intermediary's position paper Exhibits I-11, I-12, & I-14.

[50] See Intermediary's position paper Exhibit I-12.

[51] See Intermediary's position paper Exhibit I-46.

transaction in this case follows merely by substituting "the Foundation" in that case with "Cushing and Goddard,"and changing "SPMH" to "Good Samaritan." The Intermediary argues that the point to be taken from Sid Peterson is that there is no one particular time period to review in order to decide whether the transaction is "between" related parties. The Intermediary relies on numerous other court and administrative decisions that it contends have made related party determinations that required a review of both the "before" and "after" sides of transactions that are similar to the one in this case, citing The Kidney Center of Hollywood v. Shalala, 133 F.3d 78 (D.C. Cir. 1998)[52] (related parties existed where former owners established and controlled purchasing corporation, even where transaction was implicitly fair); Monsour Medical Center v. Heckler,806 F.2d 1185 (3rd Cir. 1986)[53] (related parties existed where family founders, directors, officers, and owners of a hospital formed and controlled a foundation into which the hospital was converted); Hillside Community Hospital of Ukiah v. Mathews, 423 F.Supp. 1168 (N.D. Cal. 1976) [54](related parties existed where directors of buyer held significant interest in seller of building); Eastland Memorial Hospital v. Blue Cross and Blue Shield Association et al., PRRB Dec. No. 96-D37, June 20, 1996,[55] (1196-2 Transfer Binder) Medicare and Medicaid Guide (CCH) ¶ 44,478, declined rev. HCFA Admin., July 23, 1996, (related parties found where common members existed in boards of corporations transferring and receiving hospital).

The Intermediary responds to Providers' position that the HCFA Manual supports Providers by saying that, MIM § 4502.7,[56] after restating 42 C.F.R. § 413.134(1)(3)(i)[57] correctly, does give an example of a consolidation in which the combining corporations (one of which is a provider) are described as unrelated parties and the new corporation is allowed a revaluation of assets. The Intermediary does not believe the example is meant to instruct intermediaries to restrict a review of a consolidation to the relationship between the pre-existing corporations, as suggested in the June 6, 1994 letter from the Providers' consultant to HCFA.[58] The example given states only that the two corporations were unrelated prior to consolidation. Importantly, the example also says, "the RO determines that the consolidation constitutes a CHOW [change of ownership] for Medicare certification purposes." To make such a finding, the regional office in that case must have concluded, unlike the regional office in this case, that the resulting corporation was unrelated to the previous corporations. Thus, the example is consistent with the Intermediary's view that both sides of a consolidation transaction should be reviewed to determine whether the transaction is "between" related parties.

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[52] See Intermediary's position paper Exhibit I-38.

[53] See Intermediary's position paper Exhibit I-39.

[54] See Intermediary's position paper Exhibit I-41.

[55] See Intermediary's position paper Exhibit I-47.

[56] See Intermediary's position paper Exhibit I-35.

[57] See Intermediary's position paper Exhibit I-26.

[58] See Intermediary's position paper Exhibit I-4 at 2.

The Intermediary cites, as further support for its contention that both sides of the transaction must be reviewed, three HCFA Pub. 15-1 sections discussing related party transactions: §1004.4, §1011.1, and §1011.4.[59] In example 2 of § 1004.4 (also referenced in § 1011.1), a management company and a provider are originally unrelated, but the arrangement/agreement into which they enter creates a related party situation. The Intermediary contends that, in this case, Cushing and Goddard are originally unrelated, but the arrangement/agreement to consolidate into Good Samaritan creates a related party transaction.

The Intermediary directs us to HCFA's March 6, 1996 memorandum to the regional office in this case,[60] wherein, HCFA's central office pointed to the second example in § 1011.4 to illustrate the "continuity of control" before and after a transaction that makes the parties to it related. That example states:

> The owners of a 200-bed hospital convert their facility to a nonprofit corporation. The owners sell the hospital to a nonprofit corporation under the direction of a board of trustees made up of former owners of the proprietary corporation. Both corporations are considered related organizations; therefore, the asset bases to the nonprofit corporation remain the same as contained in the proprietary corporation's records, and there can be no increase in the book value of such assets.

In a separate March 6, 1996 letter to an attorney, HCFA's central office made similar but more detailed remarks, although that case involved a merger rather than a consolidation.[61]

In response to the Providers' argument that Cushing and Goddard could not be related to Good Samaritan because they no longer existed at the time Good Samaritan was created,[62] the Intermediary notes that the Providers rely on the language in 42 C.F.R. § 413.134(f)(2)[63] that allows a non-surviving, non-related merger partner to claim a loss upon a merger transaction. This was also the argument raised by the attorney for a different provider, which prompted the March 6, 1996 reply letter from the HCFA central office.[64] At that time, the attorney also cited Buckingham.[65]

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[59] See Intermediary's position paper Exhibit I-32.

[60] See Intermediary's position paper Exhibit I-12.

[61] See Intermediary's position paper Exhibit I- 13.

[62] See Intermediary's position paper Exhibits I-20 and I-21 at 7-8.

[63] See Intermediary's position paper Exhibit I-26.

[64] See Intermediary's position paper Exhibit I-13 at 1 ("Moreover, you point out that, once the merger was complete, because there was one surviving entity, there were not two parties to which one could apply the related organizations principle.").

[65] See Intermediary's position paper Exhibit I-40.

The Intermediary argues that as HCFA pointed out in its reply, that argument is essentially the same as the "look only at the relationships prior to the transaction" argument.[66] What HCFA found in the fact situation presented by that attorney, what HCFA found in the case of Cushing and Goddard, and what HCFA found lacking in Buckingham was a "continuity of control."[67] The Intermediary insists that the regulations, manual instructions, and prior adjudications of countless factual situations all have that consideration as paramount: Was there a continuity of control, or did the prior holder of the assets walk away from those assets, leaving him/her/them with a recognizable gain or loss on the transaction?

The Intermediary emphatically argues that, in this case, the parties before the transaction are the parties after the transaction. Consequently, this transaction was little more than a reorganization, with obvious related party consequences. See Memorial Hospital of Long Beach v. Aetna Life Insurance Company, PRRB Dec. No. 91-D17, Jan. 31, 1991, Medicare and Medicaid Guide ¶ 39,061.[68]

Assuming that the Board considers the consolidation to be equivalent to a "sale," the Intermediary contends that the regulations at 42 C.F.R. § 413.134(f)(2)[69] only allow gains and losses to be recognized on "bona fide" sales. The Intermediary believes that Good Samaritan can not be considered a bona fide purchaser because it fails in at least two respects: 1) the full price for the property was not paid (or even determined), and 2) Good Samaritan advanced no new consideration.

While no regulation or manual instruction defines "bona fide," the Intermediary interprets the regulations to specify that the concept is one of "price" measurement. 42 C.F.R. § 413.134(b)[70] states:

> (2) Fair market value. Fair market value is the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price is the price that bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

The Intermediary argues that, in this case, there was no attempt to discern the "full price for the property" or determine the "fair market value" (§ 413.134(b)(2)), as there was never any

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[66] See Intermediary's position paper Exhibit I-13 at 2 ("Your conclusion is based largely on the relationship between the providers before the merger.").

[67] See Intermediary's position paper Exhibits I-20 and I-21.

[68] See Intermediary's position paper Exhibit I-49.

[69] See Intermediary's position paper Exhibit I-26.

[70] See Intermediary's position paper Exhibit I-26

discussion of price and never any attempt to place either facility on the market at all. All the "bargaining" was between Cushing and Goddard: Good Samaritan had no role in fixing the price of Cushing and Goddard. Rather, the transaction that Cushing and Goddard arranged was designed to merge or consolidate friendly partners, not sell either facility to Good Samaritan at the best possible price.

The Intermediary urges the Board to reject the Providers' assertion that they should be allowed to fix a purchase price for cost report purposes without appraisals, since there is no evidence of arm's length bargaining that produces fair market value.[71]

Because "there is insufficient documentation of the current fair market value of each asset," the Intermediary contends that an appraisal is usually required to determine the appropriate gain or loss. 42 C.F.R. § 413.134(f)(2)(iv),[72] HCFA Pub. 15-1 § 134.2.[73] The Intermediary agrees that there is no need for an appraisal, albeit because the issue is moot for lack of any fair market bargaining in this case, not because there is a dispute about possible market values. Indeed, there was an incentive to get the worst possible "price" in order to increase reimbursable losses to the Medicare program.

The Intermediary refers us to Mary Thompson Hospital v. Sullivan, 92 C 0986 (N.D. Il. 1992), (1993-1 Transfer Binder) Medicare and Medicaid Guide (CCH) ¶ 40,793[74] at 32,812, wherein the court commented,

> The purpose of Medicare's bona fide sale requirement is to ensure that the amount received on disposal of an asset is an even better proxy for actual expenses than accounting depreciation would be. Even if the Hospital had transferred title to HUD within a year, it could not be said that a bona fide sale occurred for purposes of the regulation because the transfer would not provide any information about the actual market value of the facilities. Compare the Hospital's situation, for example, to a provider that had actually made a gift of assets; certainly that provider would not be able to recoup the lost asset value consistent with Medicare's directive that providers only receive costs actually incurred. Put simply, without the assurance that an arms length market transaction provides as to an actual gain or loss, the Secretary has determined that a provider is only entitled to the stylized accounting depreciation loss--a loss the Hospital has already received.

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[71] See Intermediary's position paper Exhibits I-20, and 1-21 at 10-11, citing Vallejo, Providers' Exhibit P-10, Peninsula Providers' Exhibit P-11; and Care Plus Providers' Exhibit P-12.

[72] See Intermediary's position paper Exhibit I-26.

[73] See Intermediary's position paper Exhibit I-31.

[74] See Intermediary's position paper Exhibit I-43.

Without an appraisal and without any evidence of price bargaining by any party, the Intermediary contends that there is no "information about the actual market value of the facilities" and no bona fide sale.

In Lac Qui Parle, at 44,473, the Board found that a bona fide sale had occurred based on three significant facts which the Intermediary asserts are not present in this case:

> The Board finds that there is substantial evidence in the record which demonstrates that (1) MHA made a competent and reasonable solicitation effort to potential purchasers of its small rural hospital facility; (2) the parties negotiated in good faith to establish a sales price that was consistent with the terms, obligations and stated conditions which were negotiated, understood and accepted by all parties; and (3) an actual sale and transfer of assets was consummated between unrelated-parties as documented by the "Asset Purchase Agreement," wherein valuable consideration was given by buyer and seller and the duties and obligations of both parties were disclosed fully.

The Intermediary argues that both Ashland and Edgecombe,[75] relied on by the Providers, are not on point in that there were appraisals, there were price negotiations, and funds ("new consideration") did actually change hands.

The Intermediary argues, in the alternative that if the Providers are to be allowed to claim losses on "sales" of their facilities, then 42 C.F.R. § 413.134(f)(2)(iv)[76] must be applied:

> If a provider sells more than one asset for a lump sum sales price, the gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sales price among all the assets sold, in accordance with the fair market value of each asset as it was used by the provider at the time of sale.

HCFA Pub. 15-1 §§ 104.14 and 4506.1.[77]

The Intermediary complains that since the Providers did not submit their calculations to the Intermediary or the Board in connection with this appeal, they have not demonstrated that they have met the terms of the regulatory provision on the allocation of the sale price and are not entitled to claim any losses in connection with those "sales."

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[75] See Providers' position paper Exhibit P-7 and Exhibit P-9.

[76] See Intermediary's position paper, Exhibit I-26.

[77] See Intermediary's position paper, Exhibits I-29 & I-36.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTION:

1. Laws – 42 U.S.C.:

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| §1395 et seq. (§ 1801 of the Social Security Act) | - | Prohibition Against Any Federal Interference |

2. Regulations - 42 C.F.R:

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| § 405.1801 | - | Introduction |
| § 405.1803 | - | Intermediary Determination and Notice of Amount of Program Reimbursement |
| § 405.1835 | - | Right to Board Hearing |
| § 405.1839 | - | Amount in Controversy |
| § 405.1867 | - | Sources of Board's authority |
| § 413.17 et seq. | - | Cost to Related Organizations |
| § 413.24 | - | Adequate Cost Data and Cost Finding |
| § 413.134 et seq. | - | Depreciation: Allowance for Depreciation |

3. Program Instructions – Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

| | | |
|---|---|---|
| § 104.10 | - | Historical Cost |
| § 104.14 | - | Purchase of Facility as an On-Going Operation |
| § 104.15 | - | Fair Market Value |
| § 130 | - | Disposal of Assets |
| § 132 | - | Gains and Losses on Disposal of Depreciable Assets |

(Excluding Involuntary Conversions)

| | | |
|---|---|---|
| § 134.2 | - | Need of Appraisal for Program Purposes |
| § 1000 | - | Principle |
| § 1002.1 | - | Related to the Provider |
| § 1002.3 | - | Common Ownership |
| § 1004 | - | Determination of Common Ownership Control in the Provider Organization and Supplying Organization |
| § 1004.3 | - | Control Rule |
| § 1004.4 | - | Examples of Control |
| § 1011.1 | - | Contracts Creating Relationship |
| § 1011.4 | - | Purchase of Facilities from Related Organization |
| § 1502 | - | Final Cost Report |
| § 2921 | - | Request for Board Hearing |
| § 4502.7 | - | Consolidation |
| § 4506 et seq. | - | Revaluation of Assets and Gain/Loss Computation |
| § 4508.11 | - | Accounting Principles Bulletin (APB) No. 16 |

4. Program Instructions – Provider Reimbursement Manual, Part II :

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|---|---|---|
| § 115 | - | Cost Reports Filed under Protest |

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| § 115.1 | - | Provider Disclosure of Protest |
| §115.2 | - | Methods for Establishing Protested Amounts |

5. Cases:

Shalala v. Guernsey Memorial Hospital, 115 U.S. 1232 (1995).

The Kidney Center of Hollywood v. Shalala, 133 F.3d 78 (D.C. Cir. 1998).

Monsour Medical Center v. Heckler, 806 F.2d 1185 (3rd Cir. 1986).

Nursing Center of Buckingham and Hampden, Inc. v. Shalala, 990 F.2d 645 (D.C. Cir. 1993).

Hillside Community- Hospital of Ukiah v. Mathews, 423 F. Supp. 1168 (ND. Cal. 1976).

Mary Thompson Hospital v. Sullivan, 92 C 0986 (N.D. Il. 1992), (1993-1 Transfer Binder) Medicare and Medicaid Guide (CCH) ¶ 40,793.

Eastland Memorial Hospital v. Blue Cross and Blue Shield Association et al., PRRB Dec. No. 96-D37, June 20, 1996, (1996-2 Transfer Binder) Medicare and Medicaid Guide (CCH) ¶ 44,478, declined rev. HCFA Admin., July 23, 1996.

Buckingham Valley Nursing Center v. Aetna Life and Casualty- Company, PRRB Dec. No. 90-D13, Jan. 30, 1990, (1991 Transfer Binder) Medicare and Medicaid Guide (CCH) ¶ 38,369, aff'd HCFA Admin., March 28, 1990, Medicare and Medicaid Guide (CCH) ¶ 38,459.

Memorial Hospital of Long Beach v. Aetna Life Insurance Company, PRRB Hearing Dec. No. 91-D 17, Jan. 31, 1991, (1991 Transfer Binder) Medicare and Medicaid Guide (CCH) ¶ 39,061, declined rev. HCFA Admin., March 25, 1991.

Manor Health Care Corp. v. Pennsylvania, 1100 C.D. 1987 (Pa. Commw. Ct. 1988), (1989-2 Transfer Binder) Medicare and Medicaid Guide (CCH) ¶ 37,980.

Sid Peterson Memorial Hospital v. Blue Cross and Blue Shield, PRRB Dec. No. 99-D24, Feb. 23, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,161, declined rev. HCFA Admin., April 28, 1999.

Ashland Regional Medical Center v. Blue Cross and Blue Shield Assoc., PRRB Dec. No. 98-D32, Feb. 27, 1998, Medicare and Medicaid Guide (CCH) ¶ 46,109, declined rev. HCFA Admin., March 22, 1998.

Lac Qui Parle Hospital of Madison, Inc. v. Blue Cross and Blue Shield Assoc., PRRB Dec. No. 95-D37, May 10, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,269, declined rev. HCFA Admin., June 23, 1995.

Edgecomb General Hospital v. Blue Cross and Blue Shield Assoc., PRRB Dec. No. 93-D87, Sept. 9, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,704, declined rev. HCFA Admin., October 27, 1993.

Vallejo General Hosp. v. Bonen, 851 F.2d 229 (9th Cir. 1988).

Peninsula Medical Center v. Blue Cross and Blue Shield of Florida, PRRB Dec. No. 94-D62, July 29, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,614, declined rev. HCFA Admin., September 7, 1994.

Care Plus, Inc. Group Appeal v. Aetna Life Ins. Co, PRRB Dec. No. 96-D6, Jan. 29, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,010, declined rev. HCFA Admin., March 20, 1996.

Bowen v. Georgetown University Hospital, 488 U.S. 204 (1988).

Northwest Comm. Hosp. v. Califano, 442 F. Supp. 949 (S.D. Iowa 1977).

North Iowa Medical Center v. Blue Cross and Blue Shield, PRRB Dec. No. 2000-D52, May 2, 2000, (2000-1 Transfer Binder) Medicare and Medicaid Guide (CCH) ¶ 80,442, rev'd HCFA Admin. July 7, 2000, (2000-1 Transfer Binder) Medicare and Medicaid Guide (CCH) ¶ 80,519.

North Iowa Medical Center v. Department of Health and Human Services, 196 F.2d 784 (N. D. Iowa 2002) appeal docketed (8th Cir. June 2002).

Other:

HCFA Ruling 80-4

42 F.R. 17486 (April 1, 1977)

HCFA Central Office Memorandum to Regional Office (March 6, 1996)

HCFA Central Office letter (March 6, 1996)

HCFA Regional Office Memorandum to Intermediary (March 20, 1996)

Webster's Ninth New Collegiate Dictionary

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, after consideration of the parties' contentions and the evidence presented, finds and concludes that the Providers were unrelated as that term is used in 42 C.F.R. § 413.134. Revaluation of assets and recognition of gain or loss incurred as a result of the consolidation is required.

The parties agree that the transaction in issue here was a consolidation and that the regulation at 42 C.F.R § 413.134, "Depreciation: Allowance for Depreciation Based on Asset Costs," is applicable.[78] Section 413.134(l) defines a consolidation as "the combination of two or more corporations resulting in the creation of a new corporate entity."

Cushing and Goddard combined their corporations and operations to create Good Samaritan as a vehicle to continue business in what Cushing and Goddard believed would be a more economically viable structure. The two hospitals worked out the financial and operational details of Good Samaritan with the involvement of the creditors of each hospital. The terms of the transaction provided that Good Samaritan would come into existence concurrently with Cushing's and Goddard's ceasing to exist. Good Samaritan would acquire all of Cushing's and Goddard's liabilities and assets.

The Medicare regulation at 42 C.F.R. § 413.134(l)(3) provides for the reimbursement effect of a consolidation as follows:

> If at least one of the original corporations is a provider, the effect of a consolidation upon Medicare reimbursement for the provider is as follows:
>
> (i) Consolidation between unrelated parties. If the consolidation is between two or more corporations that are unrelated (as specified in § 413.17), the assets of the provider corporation(s) may be revalued in accordance with paragraph (g) of this section.
>
> (ii) Consolidation between related parties. If the consolidation is between two or more related corporations (as specified in § 413.17), no revaluation of provider assets is permitted.

[78] Although the regulation on consolidations addresses only stock transactions, the Agency interprets the regulation to apply to non-profit transactions as well. HCFA's Director of the Division of Payment and Reporting Policy, Office of Reimbursement Policy, stated in a 1986 letter that the regulation applied to non-profits. See Providers' Supplemental Exhibit D. In addition, the October 2000 "Clarification of the Application of the Regulations at 42 C.F.R. § 413.134(l) to Mergers and Consolidations Involving Non-profit Providers," HCFA Program Transmittal A-00-76, states that the regulation applies to non-profits. The "Clarification" and the Intermediary contend that "special considerations" apply, however. See Intermediary Exhibit I-55 and discussion, *infra*.

The first question to be decided by the Board is, therefore, whether the consolidation was between unrelated parties. It is undisputed that Cushing and Goddard were unrelated to each other prior to the consolidation, but the Intermediary argues that the phrase "between related parties" requires that the consolidation transaction be examined for relationships after the transaction as well. It directs us to the related party regulation at 42 C.F.R. § 413.17, which states, in pertinent part:

> (b) Definitions. (1) Related to the provider. Related to the provider means that the provider to a significant extent is associated or affiliated with or has the 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.

In particular, the Intermediary relies on subsection (3) that discusses control. It contends that because the Board of the new entity was composed of Board members of the two consolidating entities, there is a "continuity of control" that results in Cushing and Goddard each being related to the new corporation, Good Samaritan. The Intermediary contends that this relationship between the old and new entities disqualifies the transaction from revaluation of assets. In support, the Intermediary cites a HCFA Memorandum dated March 6, 1996,[79] and the October 19, 2000 HCFA publication entitled "Clarification of the Application of the Regulations at 42 C.F.R. § 413.134(l) to Mergers and Consolidation Involving Non-profit Providers." The October 2000 "Clarification" states, in part:[80]

> [W]hether the constituent corporations in a merger or consolidation are or are not related is irrelevant; rather, the focus of the inquiry should be whether significant ownership or control exists between a corporation that transfers assets and the corporation that receives them.

The Board majority finds the plain language of the consolidation regulation dispositive of the Intermediary's argument. The text, specifically, "if the consolidation is between two or more

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[79] See Intermediary's position paper Exhibit I-12.

[80] See Intermediary's position paper Exhibit I-55.

corporations that are unrelated" is crystal clear that the related party concept will be applied to the entities that are consolidating. The history of the regulation provides even more compelling evidence of the Secretary's intent to look to only the pre-transaction relationship for application of the related party principle.

Until 1977, the regulation on depreciation did not specifically include consolidations, although it did cover other types of transactions. In 1977, the Secretary proposed adding a section on mergers and consolidations. The proposed section (l) to the regulation provided in relevant part:

> [T]he consolidation of two or more providers resulting in the creation of a new corporate entity, is treated as a transaction between related parties (see 42 C.F.R. § 405.427). No revaluation of assets is permitted for those assets acquired by the surviving corporation . . .

42 F.R. 17486 (April 1, 1977).

The rule, as finally published in 1979, abandoned the blanket rule treating all consolidations as related party transactions and instead adopted the current version. In addition, the preface to the final rule conclusively resolves whether the language "between related parties" was intended to apply to the consolidating entities relationship with the new entity. The comment states that "assets may be revalued if two or more unrelated corporations consolidate to form a new corporation . . ." 44 F.R. 6912, 6913 (Feb. 5, 1979)

The Board majority, therefore, concludes that the plain language of the regulation bars application of the related party principle to the consolidating parties relationship to the new entity. The evolution and construction of the regulation reflects the Secretary's deliberate rejection of the position proposed by the Intermediary and a determination that only the relationship of the consolidating parties before the consolidation is relevant to whether assets would be revalued. The Board majority's conclusion is further buttressed by the Secretary's interpretive guidelines published in the Manual long before the October 2000 "clarification."[81] HCFA Pub. 15-1, § 4502.7[82] states, in part, with regard to consolidation, "Medicare program policy permits a revaluation of assets affected by corporate consolidations between unrelated parties."

The very nature of a consolidation being a combination of entities would likely result in some overlap of Board members between the consolidating corporations and the new entity as well as a continuation of other operations and personnel of the old organizations. It is implicit in the evolution of the regulation that the Secretary considered these factors but rejected them from the determination of whether a revaluation to the new owner was permissible.

For the same reasons, the Intermediary's arguments that the transaction fails the traditional tests of "bona fide" and "arms length" dealings as applied to Cushing's and Goddard's relationships

[81] See Intermediary's position paper Exhibit I-55.

[82] See Intermediary's position paper Exhibit I-35.

to Good Samaritan must also fail. Good Samaritan is, by definition, nothing more than a combination of the old Cushing and Goddard. That concept simply forecloses the type of bargaining between the pre and post transaction entities the Intermediary contends is necessary. Requiring "bargaining" between the old and new entity to be "arms length" would effectively nullify the regulation's directive to permit revaluation where unrelated parties consolidate.

Providers claim they also qualify for Medicare reimbursement of the loss commensurate with the revaluation, claiming it is a required second step in the process of adjusting depreciation. The Intermediary contends that gain or loss recognition is not required even if revaluation is appropriate.

We are confronted with two rules of construction, which, in this case, will produce opposite results. The Providers argue that a well established rule of construction applies. The consolidation regulation, subsection (l), must be viewed in the context of the entire regulation on depreciation, 42 C.F.R. § 413.134. Subsection (f), which deals with gains and losses, is also a part of the same regulation and an integral part of the greater reimbursement scheme on depreciation. It provides that "[i]f a disposal of a depreciable asset results in a gain or loss, an adjustment is necessary in the provider's allowable cost."

The Intermediary argues that its position is supported by an equally well established construction rule. The applicable regulation, 42 C.F.R. § 413.134 (l), includes statutory mergers as well as consolidations. The language applicable to revaluation for both merger and consolidation between unrelated parties is virtually identical. But, in sharp contrast to the consolidation part of the rule, the regulation on merger goes on to provide expressly for a gain or loss to be calculated under (f)(2). The specific inclusion of gain or loss recognition in one section but silence in a companion section evidences an intent not to permit recognition of gain or loss.

Since both interpretations are plausible, we must look for guidance in how the agency interpreted the regulation. The parties agree that the Agency guidelines specific to consolidations were published in the Manual instructions on "Change of Ownership" (CHOW), HCFA Pub. 15-1 §§ 4500-4509.[83] Under "General," the Agency describes the rapidly changing health care delivery system over two decades resulting in restructurings of provider facilities. It states in part:

> These sections present a set of working guidelines, based on existing Medicare law, regulations and implementing general instructions for use by the Medicare fiscal intermediaries and by health care providers on the reimbursement implications of various types of CHOW transactions. . . .[84]

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[83] Providers Supplemental Exhibit 1; Intermediary position paper Exhibits I-35 & I-36. The remainder of the depreciation regulation was not amended and the Manual provisions specific to gains/losses, Intermediary's position paper Exhibit I-30, do not refer to consolidations.

[84] Providers also furnished what purports to be the proposed Manual revision which also states "The Medicare program . . . has completed a review of its reimbursement policies regarding its proper participation in the costs incurred by the health care industry associated with changes of provider ownership (CHOW)." Providers' Supplemental Exhibit F, p.2.

HCFA Pub. 15-1 § 4502.7, "Consolidation," states "[a] consolidation is similar to a statutory merger, except that a new corporation is created during the consolidation . . . ." This section furnishes the following example and reimbursement effect:

> Corporation A, the provider, and Corporation B (a non-provider) combine to form Corporation C, a new corporate provider entity. By law, Corporations A and B cease to exist. Corporations A and B were unrelated parties prior to the consolidation. . . .
>
> * * * * *
>
> *A gain or loss to the seller* (Corporation A) and a revaluation of assets to the new provider (Corporation C) are computed. (emphasis added).

This statement of Medicare policy, being consistent with a reasonable, albeit not exclusive, interpretation of the regulation, resolves whether a gain or loss is to be allowed.

Despite our conclusion that the Providers *qualify* for a loss, we find that there is no clear *application* of this directive to consolidations in either the Medicare regulations or Manual. The regulation at § 413.134(l) instructs that assets are to be revalued in accordance with paragraph (g). It is entitled "Establishment of cost basis on purchase of facility as an ongoing operation." Subsection (g) does not specifically address the allocation of acquisition costs in a consolidation. It does address the typical bona fide sale situation, however.

Subparagraph (3) applies to transactions after July, 1984[85] and is pertinent here.

> (3) Assets acquired by hospitals and SNFs on or after July 18, 1984 and not subject to an enforceable agreement entered into before that date. Subject to paragraphs (b)(1)(ii)(B) through (G) and (b)(1)(iii) of this section, historical cost may not exceed the lowest of the following:
>
> (i) The allowable acquisition cost of the asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of July 18, 1984, the first owner of record):
>
> (ii) The acquisition cost to the new owner; or

[85] The Deficit Reduction Act of 1984 changed the reimbursement effect of some CHOW transactions effective July 18, 1984. The practical effect is that Medicare would no longer allow a "write up" from the historical cost basis of acquired assets; however, a "write down" could occur. Medicare Intermediary Manual § 4508.1, Providers' Post Hearing Position Paper Tab 1 (Note: this document contains two sections labeled Tab 1. The document referred to is in the first Tab 1. Documents attached to the post hearing submission are also referred to as "supplemental exhibits" but the numbers overlap Providers exhibits attached to its initial submission.

(iii) The fair market value.

42 C.F.R. § 413.134(g)(3).

Fair market value is defined as:

> [T]he price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price is the price that bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

42 C.F.R. § 413.134(b)(2).

After an analysis of paragraph (g), the Board majority concludes that it must examine the evidence to decide the availability of an "acquisition cost" or a "fair market value" of the depreciable assets in this appeal.

The Providers argue that the regulation clearly contemplates that a consolidation be treated as a "sale" under the gain or loss provision in 42 C.F.R. § 413.134(f)(2). They contend that the liabilities assumed establishes the "acquisition cost." They further contend that the acquisition cost resulted from arms length bargaining between two unrelated consolidating parties and, therefore, that it approximates fair market value. Revaluation and calculation of loss, they assert, is purely a function of allocating the acquisition cost among all the assets acquired proportionate to their fair market value.[86]

The transaction here involved disclosures of financial and operational status and a period of due diligence for the prospective constituents to evaluate the values and detriments the other would bring to the combined enterprise. Testimony of the Providers' witnesses demonstrated that value of the depreciable assets had less influence on the terms of the transaction than their organization's charitable mission and community commitments.

The October, 2000 "Clarification" relied on by the Intermediary cites the lack of motivation to maximize sales price of depreciable assets to support denying reimbursement of loss. The gain/loss regulation was not amended when the additional sections on consolidation and merger

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[86] 42 C.F.R. § 413.134(f)(2)(iv) provides that if a provider sells more than one asset for a lump sum sales price, the gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sales price among all the assets sold, in accordance with the fair market value of each asset as it was used by the provider at the time of sale. This provision also authorizes an appraisal if there is insufficient evidence of the fair market value. There is little evidence in the record to indicate the fair market value of the depreciable assets. The record does contain an appraisal done approximately three years after the transaction for one of the consolidating hospital's assets. The document specifically states that it is for internal purposes only and, because of the Intermediary's position taken in this case that no loss is recognizable, it has not done any analysis of the applicability of the appraisal to the transaction.

were added. The old sections clearly contemplate that an "acquisition cost" will have been determined through bona fide, arms length bargaining that is likely to produce fair market value. We also acknowledge that there was no "disposition" of the assets *as that term is used in the regulations on gain or loss* in that the Providers, though consolidated under a new corporate structure, continued providing substantially the same services using the same facilities and, for the most part, using the same personnel. We have already concluded, though, that the consolidation regulation as written insulates application of these principles to the relationship between the consolidating hospitals and their successor. Given the regulation's explicit limitation on application of the related party principle and the Agency's longstanding interpretation that the regulation applies to non-stock company transactions, the Board majority finds no authority in the regulation or the guidelines in effect at the time of the transaction to permit motivations unique to non-profits to be a determining factor in the reimbursement treatment.

The ultimate goal of reimbursing depreciation is to compensate the provider for actual consumption of its assets in providing care to Medicare patients. When ownership of depreciable assets changes, consumption is measured by changes in fair market value, typically reflected in the consideration paid for those assets. Assumption of debt is a well recognized component of consideration. However, in a consolidation, the terms are dictated by operation of law and there is typically no "consideration" other than the amount of liability assumed.[87]

The Board majority concludes that evidence of a changing healthcare environment and lack of a market for provider facilities is persuasive that Providers incurred a genuine financial loss. That evidence also supports Providers' position that the process of finding a suitable consolidation partner requires arms length evaluation and bargaining similar to that in a traditional sale, although the Board majority believes it may be more imprecise in producing fair market value. The Medicare Manual supports this view. HCFA Pub. 15-1 § 4508.11[88] incorporates, as part of the Manual, Accounting Board Opinion No. 16, "Business Combinations." "Medicare program policy places reliance on the generally accepted accounting principles as expressed in …. APB No. 16 in the revaluation of assets and gain/loss computation processes for Medicare reimbursement purposes."[89] APB No. 16 contains a comprehensive discussion of the advantages

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[87] We note that the greater the difference between the book value of assets and the liabilities assumed, the more difficult the application of typical allocation methodologies become. To illustrate, Corporation A and B consolidate to form Corporation C. A has been prosperous, has high utilization, good revenues, assets with a book value of $200 million and liabilities of $150 million. B has foundered, occupancy has dropped precipitously, it has missed debt payments and is considering closing. It has assets with a book value of 200 million but it has liabilities of $225 million. Applying the Provider's Position would result (assuming 100% Medicare utilization) in Medicare paying for a higher loss on the well run, prosperous phospital A and recouping a gain on the poor performing hospital B. In this case, Cushing, the most efficient and least debt ridden of the two consolidating hospitals would create a bigger loss to Medicare than Goddard's heavy debt and poor revenues.

[88] See Providers' Post-Hearing Brief Exhibit 1.

[89] The Manual cautions, though, that in certain areas, Medicare policy deviates from that in generally accepted accounting principles.

and disadvantages and the practical difficulties of treating a combination as a purchase.[90] Paragraph 19, entitled "A bargained transaction," states that proponents of the purchase method recognize a business combination as " . . . a significant economic event that results from bargaining between independent parties. Each party bargains on the basis of his assessment of the current status and future prospects of each constituent as a separate enterprise and as a contributor to the proposed combined enterprise. The agreed terms of combination recognize primarily the bargained values and only secondarily the costs of assets and liabilities carried by the constituents . . ." The Board majority concludes that the assumption of liabilities through a consolidation transaction is persuasive evidence of acquisition costs.[91] Liabilities assumed in a consolidation also may, but do not necessarily, equate to fair market value.

With regard the calculation of the loss, the Board has considered various allocation methodologies,[92] the applicable authorities, and the evidence. The Board majority concludes that the acquisition cost, that is, the amount of assumed liabilities, should be prorated among all of the Providers assets. This method is set out in 42 C.F.R. § 413.134(f)(2)(iv) and is applicable to bona fide sale of assets. This method will give equal weight to all of the assets in the sharing of the acquisition cost and all assets' valuation will be changed by the same percentage. The Manual also provides further asset allocation guidelines for this methodology at HCFA Pub. 15-1 § 4506 under "Revaluation of Assets and Gains/Loss Computation. Because the Intermediary took the position that the Providers were not entitled to recognition of a loss, it has not analyzed the figures provided by the Providers or the calculations. We must, therefore, remand this matter to the Intermediary for consideration of the calculation in light of this opinion, the regulations and HCFA Pub. 15-1.

DECISION AND ORDER:

The Intermediary's determination to deny the Providers' loss on consolidation was improper and is reversed. This matter is hereby remanded to the Intermediary for calculation of the loss consistent with this decision, the regulations at 42 C.F.R. § 413.134(f)(2)(iv) and the Medicare Manual, HCFA Pub. 15-1 § 4506.

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[90] See footnote 100, supra.

[91] Acceptance of the amount of liabilities assumed as the acquisition cost is the position taken by HCFA's Director of the Division of Payment and reporting Policy, Office of reimbursement Policy, in a 1987 letter. Provider Supplemental Exhibit D.

[92] Under the APB No. 16 methodology, consideration is first allocated to monetary and current assets and then the remaining consideration is allocated to non-monetary assets. This method can result in there being little or no consideration applied to the depreciable assets that may have a substantial book value. Under the methodology prescribed in the regulation applicable to bona fide sale, consideration is allocated proportionally among all the categories of assets that are transferred. This method has its own anomaly in that in some cases it may force the allocation of inadequate consideration to liquid assets such as cash and equivalents. The proportionate value method was recognized as appropriate for consolidations by the Director of HCFA's Office of Payment Policy. See Exhibit H, Providers' Nov. 11, 1999 Supplemental Exhibits.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire (Dissenting Opinion)
Stanley J. Sokolove
Dr. Gary Blodgett
Irvin W. Kues

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

Dissenting Opinion of Henry C. Wessman, Esquire

I dissent.

I begin this dissent with the most basic of legal principles: in order for a suit (or Appeal) to move forward, the Plaintiff (Provider/Appellant) must state a "case or controversy", the basis of harm for which the Defendant (Intermediary) is responsible. Further, in order for the Court (or PRRB) to provide relief, the Provider must clearly "state a cause upon which relief can be granted". Fed.R.Civ.P. 12(b). In the instant case, the Provider has done neither.

In their rush to judgment for the Provider in this, the first of several "loss on consolidation" appeals, the PRRB Majority blows by these most basic of jurisdictional questions, and, I think, finds for the Provider. I qualify my statement with "I think", because, by the very wording of the final Decision and Order (". . . remanded to the Intermediary for calculation of the loss . . ." supra at 33), it is clear that even the PRRB Majority has no clue as to the harm, if any, that quantifies as "relief" and provides a remedy.

42 U.S.C. § 1395oo et seq, and promulgations, detail the codification and implementation of Social Security Act § 1878, establishing the Provider Reimbursement Review Board. For purposes of PRRB jurisdiction, the appropriate "case or controversy" applicable to the instant case is satisfied if: the Provider is dissatisfied with a final determination by the Fiscal Intermediary (FI) of total reimbursement on the NPR, where an adjustment to a cost report item has been made, and the adjustment is $10,000 or more, and the appeal is timely filed within 180 days of the final determination. The "$10,000 or more" establishes the basis upon which relief can be granted. The elements of the "case", all of which must be present, include Provider dissatisfaction, final determination by the FI, adjustment by the FI, impact of $10,000 or more, and timely filed appeal.

In the instant appeal, the best we can find is some confusion on the part of the Provider as to whether they were harmed (Tr. at 20 –21; Intermediary Position Paper, Exhibits I-8 and I-17) or dissatisfied; no claim of loss on the Provider's cost report (Tr. at 23-24), and thus no adjustment by the FI on final determination (Tr. at 26-27); and no documentation of the required $10,000 threshold (as evidenced by lack of claim on the cost report (Tr. at 23-24, 26-27) and inability of PRRB Majority to identify a basis upon which to grant relief (Supra at 33)). Finally, as noted by the Intermediary (Intermediary Position Paper, pp. 8- 16) the "appeal" is not timely, as the ostensible "losses" occurred in 1993, not 1994. In short, the PRRB does not have jurisdiction in this case because there really is no case.

Now, it is my humble opinion that, the PRRB being in the awkward position of having taken jurisdiction over a "non-case", meticulously going through the Position Papers and Exhibits, and having held a two day Hearing, and yet not being able to articulate any quantification of relief should perhaps result in identification of something akin to "Summary Judgment" or demurrer for the Intermediary as the appropriate solution.

Recognizing the factors noted above, the PRRB Majority nonetheless did accept jurisdiction over this appeal, did hold a Hearing, and did issue a Decision. As best I can understand, the PRRB Majority found the following factors significant:

1) the Providers were unrelated prior to the consolidation (supra at 25);
2) there was a consolidation (supra at 25);
3) revaluation of assets and recognition of gain or loss is required of the consolidation (supra at 28), in accordance with 42 C.F.R. § 413.134 et seq "Depreciation: Allowance for Depreciation Based on Asset Costs", including "bona fide" sale characteristics of "arms-length" negotiations to establish fair market value. § 413.134(g)(3) and § 413.134(b)(2); (supra at 30);
4) Medicare permits a revaluation of assets (a gain/loss to seller, a revaluation of assets to new provider) for a consolidation between unrelated parties where a CHOW results, and appropriate terminating cost reports and tie-in notice is issued (supra at 29, Intermediary Position Paper, Exhibit I-35);
5) Majority notes there is ". . little evidence in the record to indicate the fair market value of the depreciable assets" (Footnote 54);
6) Majority does not accept "motivation" of non-profit providers to be a determining factor in the reimbursement treatment (supra at 32);
7) Majority finds that "in a consolidation, the terms are dictated by operation of law and there is no "consideration" other than the amount of liability assumed" (supra at 32);
8) that, despite #3, 4, 5, 6 and 7 above, the Board Majority " . . .concludes that evidence of a changing healthcare environment and lack of a market for provider facilities is persuasive that providers incurred a genuine financial loss". Then, to complete this boot-strapping circumambage,
9) the Board Majority " . . .concludes that the assumption of liabilities is persuasive evidence of acquisition costs" and "may" serve as a surrogate for fair market value (supra at 33), with a final Decision and Order that
10) the entire matter be " . . .remanded to the Intermediary for calculation. ." to try and figure out what # 1 – 9 really mean.

I continue to insist that this is a non-case. There was no loss claimed on any cost report – PRRB Member Hoover underscored, and reinforced that response (Tr. at 23-24) from the Provider. In fact, the Provider responded to Member Barker that they had [not] ". . .took [a loss] into their calculations on the preparation for this transaction", a response Member Barker labeled as "naïve". (Tr. at 20-21). The Provider also responded to Member Hoover that there was no terminal cost report filed in any year (Tr. at 25) – all of which reinforces the fact that there simply is not cause of action here, and no PRRB jurisdiction.

I further question the Majority's magnanimous assumption that, because of "evidence of a changing healthcare environment" and "lack of market for provider facilities" the Providers in the instant case must have "incurred a genuine financial loss". (supra at 32). It is simply not that obvious (as evidenced by the Majority's Final Order), not that easy, to make the quantum leap from over bedding and inefficiencies in a given region to automatically translate into a bail out by the Medicare Trust Fund. Somewhere in the middle, there has to be some evidence of a bona

fide sales-characteristic loss-on-consolidation, a claim to Medicare for that loss on a cost report, a denial of that claim, and a timely appeal. None of that appears in the instant case.

What does appear to be here is the fact that there were admittedly two struggling healthcare providers, who, in a pre-meditated manner, "consolidated" as any prudent business operators would do to enhance their chances for survival through increased efficiencies-of-scale and reduced costs. This is well and good, but again, in my humble opinion, they should not, absent meeting the tests of 42 U.S.C. § 1395oo et seq; 42 C.F.R. § 413.134 et seq, particularly § 413.134(g)(3) and § 413.134(b)(2), and HCFA Pub.15-1 § 4502.7, expect the Medicare Trust Fund to pick up the tab for prior inefficiencies under the guise of "loss on consolidation". This is particularly so in the absence of any hint of the § 413.134 et seq bona fide "arms length," "willing seller, willing buyer", get-the-best-price for your facility negotiation prior to consolidation. That, incidentally, is what distinguishes this instant "loss on consolidation" case from the '90's "gain on sale" progeny; the test of "bona fide" effort is the same, and must be met. It has not been met here. At the very least I would expect to find some documentation, some evidence, of a good faith effort on the part of each unrelated party to at least attempt to reduce individual debt load prior to consolidation in an effort to give the new consolidated entity the best possible chance for economic survival. In the real world of business, that is what would happen. Such evidence, in my opinion, would go a long way toward satisfying § 413.134 et seq and the 1979 Final Rule. In the surreal business world of healthcare, however, the goal is to manipulate the system via asset, depreciation and liabilities assignment so that the deep pockets of the Medicare Trust Fund covers past inefficiencies.

I am also not fully convinced that the consolidating parties were "unrelated". As a unanimous PRRB noted in Sid Peterson Memorial Hospital (Intermediary Position Paper, Exhibit I-46; Provider Position Paper, Exhibit P-9), continuity of control is a potent tool, and a strong indicator of the intent and prior behavior of the parties. Couple this with the fact that there were no terminal cost reports (Tr. at 25), no tie-in notices in evidence, continuation of provider numbers after consolidation (Tr. at 26), and an initial 87.5% carryover on the Board of Directors from the consolidating hospitals to the consolidated Board (Intermediary Position Paper at 12) all suggests that, at best, we are dealing here with a reorganization under a new name. This may have been what the PRRB Majority was referring to with the statement of not allowing ". . .motivations unique to non-profits to be a determining factor in the reimbursement treatment" (supra at 32). But that appears to be part of the driving force in their Decision.

The Provider, displaying uncertainty and ambivalence toward their "losses" (Tr. at 20-24), claimed depreciation on their cost reports as though they were not intending to claim "loss on consolidation", and as though the reorganized entity was not entitled to claim a revaluation of assets as a result of the consolidation (Intermediary Position Paper at 49; Exhibit I-8). Obviously, the Providers knew, prior to consulting with the experts, that they could not have it both ways. So did the Intermediary – they allowed the appropriate depreciation costs as filed. Not surprisingly, there is precedent for Medicare's insistence on only paying once, and accurately. In Mary Thompson Hospital v. Sullivan, the Court notes that "Put simply, without the assurance that an arms length market transaction provides as to an actual gain or loss, the Secretary has determined that a provider is only entitled to the stylized accounting depreciation loss- - a loss the Hospital has already received".

Once again, even if it is somehow determined that the now-reorganized hospitals were once totally unrelated, the act of consolidation in the instant case does not pass the Taxpayer protection safeguard mechanism of § 413.134 et seq, because there is not evidence of a bona fide "arms length", "willing seller, willing buyer", get-the-best-price for your facility negotiation. In my opinion, this was the import and significance of the Final 1979 Rule (Provider Supplemental Exhibit B) – a foresighted recognition that there could be future consolidations with losses, just as there were consolidations with gains, and that the same "arms length" negotiation test would be applied uniformly to both gains and losses. That did not happen in the instant case. Also, again, as noted in § 4507.2 (Intermediary Position Paper, Exhibit I-35), consolidation between unrelated parties may result in a recognition of a gain/loss and revaluation if "a tie-in notice is issued, and [the consolidating corporation] is required to file a terminating cost report". These are just two – no shred of § 413.134 et seq evidence; a documented lack of § 4507.2 action - of a litany of unmet thresholds in this case.

Finally, and most earnestly, I simply cannot square the Majority Decision with my understanding of 42 U.S.C. § 1395x(v)(1)(A) Reasonable Costs to Medicare. There is nothing reasonable about asking the Medicare Trust Fund to cover expenses for past operating inefficiencies under the guise of "loss on consolidation" where no good faith, arms length bargaining occurred to mitigate those liabilities pre-consolidation. I would strongly disagree with the Majority position that ". . . evidence also supports Providers' position that the process of finding a suitable consolidation partner requires precisely the type of arms length evaluation and bargaining that a traditional sale produces. . " (supra at 32). The huge difference is one of getting the best price for your facility on a sale versus getting the greatest loss for Medicare to cover in a consolidation. Perhaps this is what the PRRB Majority meant in Footnote 54, when they opined that "There is little evidence in the record to indicate the fair market value of the depreciable assets". But I would boldly assert that there is a total abyss between "little evidence" in the record to the Majority's conclusion that "the assumption of liabilities [the greatest loss] is persuasive evidence of acquisition costs" that, in the instant case, "may" function as a surrogate for fair market value of the assets acquired. This is particularly true barring any pretense of the prerequisite bona fide bargaining required in § 413.134 et seq.
(SEE: Mary Thompson Hospital v. Sullivan).

One last time: there is no case here, there is no cause; the PRRB cannot, unilaterally, order the Intermediary or CMS to undo what they did not do in the first place, nor to do what the Provider has not asked them to do.

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Senior Board Member