PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D29

PROVIDER -
St. Francis Regional Medical Center
Wichita, Kansas

Provider No.: 17-0122

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/
Blue Cross Blue Shield of Kansas

DATE OF HEARING -
April 25, 2007

Cost Reporting Period Ended -
September 30, 1995

CASE NO.: 98-0892

INDEX

ISSUE:

Whether the Intermediary's adjustments disallowing a loss claimed by St. Francis Regional Medical Center upon its consolidation with St. Joseph Medical Center to form Via Christi Regional Medical Center was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This dispute arises out of the Intermediary's failure to reimburse the Provider for depreciation expense Provider claims is due under the Medicare program of the Social Security Act, 42 U.S.C. §§1395 et seq., for the 1995 cost year. The amount in contention relates to a claimed loss on the disposal of assets when two hospitals consolidated: St. Francis Regional Medical Center (Provider or St. Francis) and St. Joseph Medical Center (St. Joseph) consolidation resulted in the creation of a new entity, Via Christi Regional Medical Center (Via Christi).

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

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

Medicare reasonable cost reimbursement is governed by 42 U.S.C. §1395x(v)(1)(A). In part, the statute provides that the "reasonable cost" of any service shall be the actual cost incurred excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services. The implementing regulation at 42 C.F.R. §413.9 provides that reasonable cost includes all "necessary and proper" costs incurred in furnishing healthcare services, subject to principles relating to specific items of revenue and cost.

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 property, plant 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(b)(1). To determine annual depreciation, the historical cost is prorated over the asset's estimated useful

life in accordance with one of several methods. 42 C.F.R. §413.134(a)(3).

The calculated annual depreciation is only an estimate of the asset's declining value. If an asset is ultimately sold by the provider for less than the undepreciated 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 of DHHS (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 undepreciated basis, then a "gain" has occurred, and the Secretary takes back or "recaptures" previously paid reimbursement. 42 C.F.R. §413.134(f)(1).

Where a provider sells several assets for a lump sum sales price, the regulation at 42 C.F.R. §413.134(f)(2)(iv) requires the determination of the gain or loss (depreciation adjustment) for each depreciable asset by allocating the lump sum sales price among all of the assets sold in accordance with the fair market value of each asset as it was used by the provider at the time of sale. An appropriate part of the purchase price is allocated to "all of the assets sold" regardless of whether they are depreciable or not.

The regulation providing for gains or losses originally dealt with the disposition of assets through sale, scrapping, trade-in, exchange, donation, demolition, abandonment, condemnation, fire, theft or other casualty. In 1979 CMS extended the depreciation adjustment to "complex financial transactions" not previously addressed in subsection 42 C.F.R. §413.134(f) by including mergers and consolidations. A statutory merger between unrelated parties was treated as a disposition of assets that would trigger: (1) the revaluation of assets in accordance with 42 C.F.R. §413.134(g), and (2) the realization of gains and losses under the provisions of 42 C.F.R. §413.134(f). However, a statutory merger between related parties would not trigger a gain or loss computation. Likewise, a consolidation between two or more corporations that were unrelated resulted in a depreciation adjustment. No revaluation was allowed if related corporations consolidated. 42 C.F.R. §413.134(l)(3)(ii).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Francis Regional Medical Center (the Provider or St. Francis) is an acute care general hospital located in Wichita, Kansas. Prior to October 1, 1995, St. Francis was controlled by St. Francis Ministry Corporation (Ministry Corporation) as its sole member. St. Joseph Medical Center, Inc. (St. Joseph) was controlled by CSJ Health System of Wichita, Inc. (CSJ) as its sole member.

Effective October 1, 1995, the two hospitals consolidated under Kansas statute, resulting in the creation of Via Christi Regional Medical Center, Inc. (Via Christi). As a result of the consolidation, all the assets, rights, liabilities, and contingent liabilities of the Provider and St. Joseph passed under operation of law to the new entity, Via Christi, and the Provider and St.

Joseph ceased to exist. One day later, on October 2, 1995, CSJ and the Ministry corporation consolidated into Via Christi Health System, Inc. (VCHS or Health System).

As a result of the transaction, the Provider submitted a terminating Medicare cost report in which they claimed a loss on the disposal of their depreciable assets. The loss was represented by the difference between the net book value of the assets they transferred to VCHS and the liabilities which VCHS had assumed. The Intermediary disallowed the claimed loss on depreciable assets.

The Board has previously considered the loss on consolidation claim of St. Joseph Medical Center in *St. Joseph Medical Center v. Blue Cross Blue Shield Association/Blue Cross Blue Shield of Kansas*, PRRB Dec. No. 2003-D64, September 29, 2003, Medicare & Medicaid Guide (CCH) ¶ 81,050, *rev'd*, CMS Administrator, November 25, 2003, Medicare & Medicaid Guide (CCH) ¶81,092, *aff'd*, *Via Christi Regional Medical Center, Inc. (successor-in-interest to St. Joseph Medical Center) v. Leavitt*, No. 04-1026-WEB (D. Kansas Sept. 25, 2006), Medicare & Medicaid Guide (CCH) ¶ 301,911, *rev'd in part and aff'd in part*, 509 F.3d 1259 (10th Cir. Dec. 7, 2007) (*St. Joseph* or *Via Christi*, respectively).

The Providers appealed the Intermediary's adjustments to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $59 million.[1]

The Provider was represented by Robert E. Mazer, Esquire, of Ober, Kaler, Grimes & Shriver. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross Blue Shield Association.

STIPULATIONS OF PARTIES:[2]

1. Statements set forth in an Affidavit of Emilie Petersen dated August 28, 2000, included in Exhibit P-50.

2. Prior to the consolidation described in paragraph 5, St. Francis Regional Medical Center ("St. Francis Medical Center") was a nonprofit corporation under the laws of Kansas. St. Francis Medical Center did not have an owner. However, its sole corporate member was St. Francis Ministry Cooperation ("St. Francis Ministry"). The religious sponsor of St. Francis Medical Center and St. Francis Ministry was the Sisters of the Sorrowful Mother – U.S. Health System, Inc. ("Sorrowful Mothers Sisters".)

3. Prior to the transaction described in paragraph 5, St. Joseph Medical Center was a nonprofit corporation under the laws of Kansas. St. Joseph

[1] Exhibit P-101, P-92. (Stipulation16), Provider Post-Hearing Brief page 9.
[2] Exhibit P-92.

Medical Center did not have an owner. However, its sole corporate member was CSJ Health System of Wichita, Inc. ("CSJ"). The religious sponsor of CSJ and St. Joseph was the Sisters of St. Joseph of Wichita, Kansas ("Sister of St. Joseph").

4. Prior to the transaction described in paragraph 5, St. Francis Medical Center received Medicare reimbursement for its depreciable assets used in the provision of patient care based on the assets' historic costs and Medicare useful life guidelines.

5. Effective October 1, 1995, St. Francis Medical Center consolidated with St. Joseph Medical Center. As a result of the consolidation, good title to all of St. Francis Medical Center's assets passed by operation of law to Via Christi Regional Medical Center, Inc. ("Via Christi Medical Center"), which came into existence as a result of the consolidation. Via Christi Medical Center became legally responsible for all of St. Francis Medical Center's liabilities, including those which were actual liabilities and reflected on St. Francis Medical Center's pre-consolidation financial statements, and those liabilities which were contingent or unknown, and which were not reflected on those financial statements. As a result of the consolidation, St. Francis Medical Center ceased to exist. The transaction was a statutory consolidation under Kansas law (Kan. Stat. Ann. § 17-6709) and a consolidation under Medicare regulations, was a *bona fide* transaction entered into in good faith by the parties, was legally effective, and complied with all applicable legal and regulatory requirements. The transaction was not a sale of assets under Kansas law and did not include a donation of assets.

6. The consolidation described in paragraph 5 was consummated pursuant to the Agreement of Consolidation and the Master Plan of Consolidation included in Exhibit P-1. The Master Plan of Consolidation included the representations, warranties and other provisions typically found in such agreements negotiated by independent parties at arm's-length from one another, and the form and content of the Master Plan of Consolidation and the Agreement of Consolidation is consistent with such agreements negotiated and consummated between arm's-length parties. The consolidation was not a "reorganization" under the Internal Revenue Code, Kansas statutes, or Medicare Intermediary Manual, § 4502.10.

7. St. Joseph Medical Center and St. Francis Medical Center were not subject to common ownership or common control prior to or at the time of the consolidation transaction described in paragraph 5, including when the terms of the transaction were negotiated, when the transaction documents were executed, when the Certificate of Consolidation was filed with the Office of Secretary of State, and when the consolidation became effective. At no such time did any individual who served as a director or officer of

St. Francis Medical Center, St. Francis Ministry or Sorrowful Mothers Sisters also serve as a director or officer of St. Joseph Medical Center, CJS or Sisters of St. Joseph.

8. One day after the consolidation described in paragraph 5, St. Francis Ministry consolidated with CSJ to create Via Christi Health System, Inc. ("Via Christi Health System").

9. At no time did St. Francis Medical Center and either Via Christi Medical Center or Via Christi Health System simultaneously exist. At no time did St. Francis Ministry and Via Christi Health System simultaneously exist.

10. St. Francis Medical Center claimed a loss incurred on the consolidation described above. Specifically, by letter dated March 6, 1996, a terminating cost report was submitted to the Intermediary (Exhibit P-43). Because an appraisal reflecting the fair market value of St. Francis Medical Center's assets had not yet been received, the cost report included an estimated loss claim. The estimated loss was computed by assigning consideration of $214,641,617 — reflecting the liabilities on St. Francis Medical Center's financial statement — among St. Francis Medical Center's assets based on their proportionate *net book values*. The consideration assigned to property, plant and equipment was $85,891,054. Given their Medicare book value of $148,044,951, the total loss on those assets was $62,153,897. The Medicare portion of that loss was approximately $35 million. This computation is reflected in Stipulation Exhibit A (prepared March 2007).

11. By letter dated March 31, 1997, the Intermediary was provided with an amended cost report reflecting a revised loss calculation (Exhibit P-44). The revised calculation was based on an appraisal and related computations performed by Valuation Counselors (Exhibit P-45). In computing the loss reflected on the amended cost report, Valuation Counselors offset certain current liabilities in the amount of $33,483,699 against current assets to arrive at a value of $58,757,000 for net working capital. It then allocated the remaining consideration of $181,158,000 (total liabilities of $214,641,617 less $33,483,699) among all of St. Francis Medical Center's assets based on their proportionate *fair market values* as set forth in Exhibit P-37, including net working capital. The aggregate consideration assigned to depreciable assets was $24,577,000. The Medicare book value of St. Francis Medical Center's depreciable assets was $128,912,978. (This amount was different from the Medicare book value used in the loss computation reflected on the initial cost report claim; the initial claim had incorrectly included the book value of land, construction in process, and assets owned by a related entity, Preferred Medical Associates.) The total loss on depreciable assets was $104,335,978. The Medicare portion of the loss was approximately

$58.5 million. This computation is reflected in Stipulation Exhibit B (prepared March 2007).

12. By letter dated April 10, 1997, a corrected cost report was submitted to the Intermediary (Exhibit P-46).

13. By letter dated July 7, 1997 (Exhibit P-47), the Intermediary stated that it would not process the amended cost report that had been submitted. The initial settlement would be calculated from the previously submitted cost report.

14. As reflected on a Notice of Program Reimbursement dated September 10, 1997, the Intermediary disallowed St. Francis Medical Center's loss claim. The Intermediary's audit adjustment report stated:

> This adjustment is made to eliminate from the cost report amounts applicable to the "loss on termination" of the St. Francis Medical Center entity—which was consolidated into Via Christi. The loss is not allowable as the transaction was among related organizations. No gain/loss is recognized and no revaluation of assets is allowed.
>
> When a consolidation occurs that involves a continuity of control between the nonsurviving entities and the new, consolidated entity, the consolidation would be deemed to be between related parties. This will be a Change of Ownership for certification purposes, but would not be a Change of Ownership for payment purposes.
>
> (Exhibit P-48).

15. In making its audit determination, the Intermediary relied on the number of individuals from St. Francis Medical Center and St. Joseph Medical Center who became officers and directors of Via Christi Medical Center and on draft revisions to the Provider Reimbursement Manual providing for disallowance of a loss on consolidation when there was a "continuation of control" (Exhibits P-48, P-49). The Intermediary determined that of the twenty-one members of Via Christi Medical Center's initial governing board, eleven or 52.39% had been members of the St. Francis Medical Center or St. Joseph Medical Center board (Exhibit I-6 at 1). The Intermediary did not make a finding that the six individuals who it determined had been members of St. Francis Medical Center's twenty-four person governing board and who became members of Via Christi Medical Center's board had been able to control or significantly influence St. Francis Medical Center prior to the transaction or Via Christi Medical Center after the transaction. The Intermediary stated that individuals who

filled six of the eight pivotal Operational Positions of Via Christi Medical Center had been employed by St. Joseph Medical Center or St. Francis Medical Center prior to the transaction (Exhibit I-6 at 2). The Intermediary did not make a finding that the three individuals who it determined had been employed by St. Francis Medical Center had been able to control or significantly influence St. Francis Medical Center prior to the transaction or Via Christi Medical Center after the transaction.

16. St. Francis Medical Center asserts that the loss should be computed by assigning consideration of $214,641,617 – reflecting its financial statement liabilities assumed by Via Christi Medical Center – among all of St. Francis Medical Center's assets based on their proportionate *fair market values*. The consideration assigned to depreciable assets is $23,929,218. The Medicare book value of St. Francis Medical Center's depreciable assets was $128,912,978. The total loss on depreciable assets would then be $104,983,760. The Medicare portion of the loss is approximately $59 million. This computation is reflected in Stipulation Exhibit C (prepared March 2007). Without prejudice to the Intermediary's position that the determination of fair market value set forth in the appraisal was incorrect, the Intermediary does not contest the approach used in computing St. Francis Medical Center's loss claim reflected in Stipulation Exhibit C.[3]

17. The testimony of Robert Heath, Leroy Rheault, Michael Maher, and Eric Yospe in *St. Joseph Medical Center v. Blue Cross Blue Shield Association/Blue Cross Blue Shield of Kansas*, PRRB Case No. 98-2851 (Exhibit P-26) and the affidavit of Mr. Maher that includes statements related to application of his prior testimony to St. Francis Regional Medical Center's loss claim shall be made part of the record in this matter and shall be accepted on the same basis as if such prior testimony or statements had been made in testimony related directly to the hearing proceedings for this matter.

---

[3] In response to questions and comments from the Board, the Provider submitted a revised calculation of the loss. See Provider's Post Hearing Brief at 9 and Exhibit P-101, hereinafter referred to as "Exhibit C (to the stipulation at Exhibit P-92) as revised." In the revision, all assets and liabilities of Preferred Medical Associates (PMA) a related supplier of the Provider were eliminated. Provider's Post Hearing Brief at 9. In addition, the Provider presented an explanation of the Medicare utilization rate used in the loss calculation. Id. at 10. The Provider also adjusted the fair market value of assets that were considered property because the previous loss calculation did not assign any consideration to construction in progress. Id. The Provider also clarified the existence of funded depreciation in its new calculations. Id. at 11. And finally, the Provider clarified that Via Christi received additional Medicare depreciation payments after the consolidation because the Intermediary did not recognize the loss claimed by the Provider. Id.

18. The Intermediary's position regarding disallowance of St. Francis Regional Medical Center's loss claim is the same as its position related to disallowance of St. Joseph Medical Center's loss claim. The statements made by the Intermediary's witness in PRRB Case No. 98-2851 (Exhibit P-26) apply to St. Francis Medical Center's loss claim. Those statements shall be made part of the record in this matter and shall be accepted on the same basis as if they had been made in the testimony related directly to the hearing proceedings for this matter.

These stipulations were offered without prejudice to the Intermediary's position that the loss claim at issue has to be analyzed as arising from a transaction between St. Joseph Medical Center and Via Christi Medical Center, and the Intermediary's position that the consideration was unreasonable.

INTERMEDIARY'S CONTENTIONS:

The Intermediary indicated that its position regarding the disallowance of the Provider's loss claim is the same as its position related to the disallowance in *St. Joseph, supra*.

The Intermediary describes the "factual heart" of the Provider's argument as follows:[4] The Provider exchanged (in round numbers) assets with a book value of $368 million and a fair market value of $255 million for the assumption of $212 million in liabilities. Prorating the liabilities to the depreciable assets reflected a loss of $105 million on the PP&E depreciable assets with an allocated loss of $59 million to the Medicare Program. The Provider then argues that payment of the loss is necessary to "true up" depreciation or fairly compensate it for the actual reduction in value of the assets from the time of acquisition to the time of consolidation.

That outcome, according to the Intermediary, is totally inconsistent with the private and public posture of the participants, their financial reports, and it makes no business sense. The Intermediary also insists that neither Medicare regulations nor provider reimbursement manual provisions support that outcome.

The Intermediary acknowledges that the Medicare Program had recognized gains and losses and a corresponding revaluation of assets in transactions that were undisputedly "bona fide asset sales" between unrelated buyers and sellers as the terms were commonly understood. However, the Medicare Program had taken the position that sales of stock followed by mergers of the buying and selling corporate entities were not asset sales. The Intermediary believes that the purpose of the proposed addition of §413.134(l), the regulation in issue here, was to incorporate that policy into the depreciation regulation. The emphasis in the preamble was on asset sales executed as mergers. According to the Intermediary, consolidations presented themselves only as an afterthought. It points out that the context of the regulation change discussion was with the *bona fide* sale starting point. The requirement that a transaction that would result in a gain/loss to a buyer and

[4] See Exhibit P-101. – Exhibit C to the stipulation at Exhibit P-92 as revised.

revaluation to a seller must be a *bona fide* sale, regardless of how it is consummated, is therefore supported by the regulation.

The Intermediary argues that if we accept the Provider's position, then we must also accept the following position: The Medicare Program was very concerned that, in a transaction that was an asset sale, the parties bargain adversely to identify fair market value of the assets and that any gain/loss recognition and revaluation must be based on fair market value. There was absolutely no such concern, however, when a change of ownership transaction was executed as a merger or consolidation. CMS Pub. 13-4 §4502.7 does not support the argument that defining a transaction as a consolidation between unrelated parties is sufficient, in itself, to support the loss. The entire CHOW Manual sections on different forms of asset transfers use buyer/seller language.

The Intermediary also argues that the appealing Provider is claiming a loss on a related party transaction in that there was "continuity of control" between the consolidating entities and the new consolidated entity. The Provider's sponsoring order is one of two corporate members of the acute care hospital's parent. Also, the Board of the newly created corporation, that was the execution vehicle for the consolidation, had substantial representation from the Provider's pre-consolidation Board of Directors and the board of its partner.

The Intermediary contends that the precedents established in *St. Joseph, supra*, by the CMS Administrator and the District Court in *Via Christi, supra,* should apply to this case. In *St. Joseph*, the CMS Administrator found and the District Court affirmed that the parties were related due to the relationship between the Provider and the consolidated hospital. In the instant case as in the *St. Joseph* case, a significant number of the Provider's pre-consolidation board were members of the post-consolidation board and that the pre-consolidation sponsor was one of two voting members of the new parent corporation of the post-consolidation hospital, Via Christi. Id. Medicare & Medicaid Guide (CCH) ¶81,092 at 203,575. In addition, the CMS Administrator found that a consolidating provider must comply with the requirements of 42 C.F.R. §413.134(f) and that here, as in St. Joseph, the transfer of assets did not constitute a *bona fide* sale or meet any other criteria under which a loss on disposal of assets would be recognized as §413.134(f). In addition, there is no evidence of arm's length bargaining, nor an attempt to maximize any sale price as would be expected in an arms' length transaction. Id. at 203,577.

PROVIDER'S CONTENTIONS:

The Provider contends that the pertinent regulation, 42 C.F.R. §413.134(l)(3)(i), clearly provides that a consolidation between unrelated corporations occurs if the parties are unrelated prior to the transaction. Those regulations state that if a consolidation was between two or more unrelated corporations, the assets of the consolidating corporations were to be revalued. Id. The parties have stipulated that the transaction was a consolidation and that the Provider and St. Joseph were not subject to common ownership or control at the time of the transaction.[5]

[5] *See* Stipulations at ¶¶5 and 7.

The Providers cite to section 4502.7 of Medicare's Part A Intermediary Manual (CMS Pub. 13-4) providing an example of consolidating entities, unrelated through common ownership or control prior to the consolidation, which results in a gain or loss calculation to the seller.[6]

The Providers also contend that the Intermediary's disallowance is not based on the pertinent regulation or manual instruction but is instead based upon instructions issued by CMS after the subject cost reporting period, and which are contrary to previous regulatory interpretations.[7]

An ad hoc workgroup of HCFA and intermediary representatives was created to review program authorities regarding change of ownership transactions. With respect to mergers and consolidations, the workgroup recommended that the related party determination be based upon a comparison of control over the consolidating or merging entity prior to the transaction with the control over the consolidating or merging entity after the transaction (continuity of control). In addition, consolidations and mergers between unrelated parties had to meet the new definition of a "bona fide sale" with "reasonable consideration" before any gain or loss could be recognized. The workgroup's recommendations did not result in a revision to the regulations. However, many of its recommendations were adopted by the agency in PM A-00-76 as a clarification of existing policy – a clarification that was to be applied retroactively.

The Provider also argues that the Medicare program has repeatedly recognized a gain or loss when consolidating entities were unrelated prior to the transaction.[8] CMS Pub. 13-4 §4502.7 states:

> Consolidation.—A consolidation is similar to a 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. . . .
>
> * * * * *
>
> . . . You [the Medicare fiscal intermediary] determine that the transaction constitutes a CHOW for Medicare reimbursement purposes. A gain/loss to the seller (Corporation A) and a

[6] Provider's Post Hearing Brief at 20-21.
[7] Provider's Post Hearing Brief at 21-24.
[8] Provider's Post Hearing Brief at 14. Tr. 284-285; see also Exhibit P-26 at 425-428; Exhibit P-25 at 18.

> revaluation of assets to the new provider (Corporation C) are computed.

In addition, this policy was reaffirmed by HCFA's Director of Payment and Reporting Policy in correspondence dated May 11, 1987, and again in correspondence dated on August 24, 1994, by HCFA's Director of the Office of Payment Policy.[9]

The Provider contends that the Intermediary's related party determination is contrary to regulations addressing consolidations that require the related party determination be based on the relationship of the consolidating entities prior to the transaction. 42 C.F.R. §413.17. The parties have stipulated that no such common control or common ownership existed between the Provider and St. Joseph.[10]

The Provider points out that the 10th Circuit in *Via Christi, supra*, correctly determined that the plain language of the regulation, as well as other indications of the Secretary's intent at the time the applicable regulation was promulgated, precluded the Secretary's current "continuity of control" interpretation.[11] Id. at 1272-1274. According to the Court, in light of the agency's earlier interpretations, "the Secretary's claim that the agency has consistently addressed consolidations under a "continuity of control" standard is questionable at best . . ." Id. at1274.

The Provider contends that the regulatory requirements for a *bona fide* sale do not apply to consolidations nor does the definition of a *bona fide* sale in effect at the time require "reasonable consideration" as argued by the Intermediary (although, there is no evidence demonstrating that the Providers did not receive reasonable consideration for their depreciable assets).[12]

The parties agree that the transaction at issue was a consolidation under state law; it was not a sale of assets which is a fundamentally different type of transaction. The pertinent regulations make no mention of requiring consolidations between unrelated parties to be a *bona fide* sale before a gain or loss can be recognized. Moreover, as of the date of the subject transaction, CMS had not defined "bona fide sale" to require reasonable consideration although the Providers did receive "valuable consideration" for their assets. As a result of the assumption of liabilities by Via Christi, the Providers received over $214 million in consideration including approximately $24.5 million for their fixed assets.[13]

Finally, the Provider contends that the *Via Christi* Court incorrectly deferred to the Secretary's position that, in order for a loss on consolidation to be recognized, the transaction was required to satisfy "bona fide sale" requirements. The Provider asserts that in ignoring the agency's longstanding regulatory interpretations, the *Via Christi*

---

[9] Provider's Post Hearing Brief at 21-22. Exhibits P-8; Tr. at 247-252 and P-26 at 236, 378, respectively.
[10] Stipulation ¶ 7.
[11] Provider's letter dated December 11, 2007.
[12] Provider's Post Hearing Brief at 35.
[13] Stipulation ¶ 11.

Court erroneously concluded that statements requiring recognition of a gain or loss in accordance with 42 C.F.R. §413.134(f) required compliance with the *bona fide* sale requirements in subsection (f)(2). Id. at 1274. The Provider also asserts that the *Via Christi* Court incorrectly determined that the Secretary's current definition of "bona fide sale" – requiring an attempt to maximize sale price and reasonable consideration – was reasonable and entitled to deference, and that the Secretary only further clarified" the definition after the transaction Id. at 1274-5. The Provider claims that this interpretation ignores various definitions of *bona fide* sales under the Medicare program that had included no such requirement.[14] Finally, the Provider asserts that the *Via Christi* Court's determination that the consolidation "did not involve the reasonable consideration that a 'bona fide sale' would produce," Id. at 1274-1276, should not apply to this case. In the case of St. Joseph, the value of its current assets ($29 million) exceeded total consideration received for all of its assets ($26.1 million). In the instant case, the Provider passed $119.7 million in current assets to Via Christi, which was significantly less than its stated liabilities of $212.3 million that were assumed.[15] The Provider maintains that the evidence in the record supports its assertion that it received reasonable compensation for its assets.[16]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes that the Provider was unrelated to St. Joseph Medical Center prior to the consolidation as that term is defined and applied under the regulatory provisions of 42 C.F.R. §§413.17 and 413.134. Accordingly, a revaluation of assets and the recognition of the loss incurred as a result of the consolidation is required under the specific and plain meaning of 42 C.F.R. §413.134(1)(3)(i).

The parties agree that the transaction at issue was a consolidation under Kansas law and that the regulation at 42 C.F.R. §413.134, "Depreciation: Allowance for depreciation based on asset costs," is applicable.[17] Section 413.134(1)(3) defines a consolidation as "the combination of two or more corporations resulting in the creation of a new corporate entity."[18] It is undisputed that the Provider and St. Joseph consolidated, resulting in the

---

[14] Provider's Post Hearing Brief at 39-43; *See*, Provider's letter dated December 11, 2007.

[15] Id. *See* Exhibit P-101.

[16] Provider's Post Hearing Brief at 43-47.

[17] While the Board is aware that the preamble of the regulation on consolidations mentions only stock transactions, HCFA interprets the regulation to apply to nonprofit transactions as well. HCFA's Director of the Division of Payment and Reporting Policy, Office of Reimbursement Policy, stated in a 1987 letter that the regulation applied to consolidations of nonprofits. In addition, the October 2000 "Clarification of the Application of the Regulations at 42 C.F.R. §413.134(1) to Mergers and Consolidations Involving Non-profit Providers," HCFA Program Memorandum No. A-00-76, states that the regulation applies to nonprofits; however, "special considerations" apply. Exhibit P-64.

[18] *See Cardinal Cushing Hospital/Goddard Memorial Hospital v. Blue Cross and Blue Shield Ass'n/Associated Hospital Services of Maine*, PRRB Dec. No. 2003-D6, Nov. 27, 2002, Medicare and Medicaid Guide (CCH) ¶80,950,(*Cardinal Cushing Hospital/Goddard Memorial Hospital)*for a thorough discussion of the Board's view of consolidation on facts similar to those in this case.

creation of Via Christi, with the pre-existing entities ceasing to exist. Under the terms of the transaction, Via Christi (the consolidated corporation) acquired all of the assets and assumed all of the liabilities associated with the operations of the pre-existing entities.

Medicare regulation 42 C.F.R. §413.134(1)(3) provides for the reimbursement effect of a consolidation as follows:

> [i]f 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.

The first question to be decided by the Board is, therefore, whether the consolidation was between unrelated parties. It is undisputed that the Provider and St. Joseph were not related to one another prior to the consolidation. However, the Intermediary argues that the phrase "between related parties" requires that the consolidation transaction be examined for relationships after the transaction as well. Regulation 42 C.F.R. §413.17 states, in pertinent part:

> (b) *Definitions. (1) Related to the provider*. Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.
>
> (2) *Common Ownership*. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.
>
> (3) *Control*. Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

Relying on subsection (3) that discusses control, the Intermediary contends that because the board of directors of the new entity, Via Christi, was composed of board members of the consolidating entities, there is a "continuity of control" that results in the Provider being related to the new corporation, Via Christi. The Intermediary contends that this relationship between the consolidating corporations and the new corporation disqualifies

the transaction from a revaluation of assets and the concomitant loss on consolidation. In support of its position, the Intermediary cites to PM A-00-76, dated October 19, 2000, entitled "Clarification of the Application of the Regulations at 42 C.F.R. §413.134(1) to Mergers and Consolidations Involving Non-profit Providers." In part, the PM states:

> . . . whether 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 finds that the plain language of the consolidation regulation directly contradicts CMS' purported "clarification" and is dispositive of the Intermediary's argument.[19] The text at 42 C.F.R. § 413.134(l)(3)(i) which states, "if the consolidation is between two or more corporations that are unrelated," is unambiguous in requiring that the related party concept be applied to the entities that are consolidating as they existed prior to the transaction. The Board, therefore, concludes that the plain language of the regulation bars the application of the related party principle to the consolidating parties' relationship to the consolidated entity that results from the transaction. The construction of the regulation mandates a determination that only the relationship of the parties participating in the consolidation before it was completed is relevant to whether the assets would be revalued and a gain or loss recognized. The Board's conclusion is further buttressed by the Secretary's interpretive guidelines at CMS Pub. 13-4 §4502.7, which includes an example demonstrating that the related party determination is based on the relationship of the consolidating parties prior to the consolidation.

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 (1) to the regulation provided in relevant part:

> . . . the 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 Fed. Reg. 17486 (April 1, 1977).[20]

---

[19] The Board acknowledges the Providers' argument that PM A-00-76 was spurred by the program's sustained losses on mergers and consolidations as captured in an OIG report, and notes that the provisions of the memorandum were not incorporated into the program's published regulations. Provider's Post Hearing Brief at 16-18.

[20] Exhibit P-14.

However, the regulation, as finally published in 1979, abandoned the proposed blanket treatment of 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 Fed. Reg. 6912, 6913 (Feb. 5, 1979).[21]

Further indication of the Secretary's interpretation of the consolidation regulation can be found in two letters that presented written interpretations from high-level HCFA officials. In a letter dated May 11, 1987,[22] HCFA's Director of the Division of Payment and Reporting Policy, Office of Reimbursement Policy, responded to an inquiry concerning the application of the gain and loss provisions to mergers or consolidations of non-profit hospitals. The conclusion of this letter was that a consolidation between non-profit providers gives rise to the revaluation of assets and an adjustment to recognize related gains and losses. The letter also made it clear that, notwithstanding the reference to "capital stock" in the caption of the regulation, the Secretary looked to that regulation for authority in addressing mergers and consolidations of non-stock issuing corporations because the principles involved would be the same. In a letter dated August 24, 1994, the Director, Office of Payment Policy, Bureau of Policy Development, agreed that a consolidation involving not-for-profit entities required a determination of a gain as loss under §413.134(f).[23]

The Board finds that the transaction that resulted in the formation of Via Christi was a *bona fide* transaction under Kansas corporation law. The completed transaction consolidated two hospital corporations into one new entity, with the preexisting entities ceasing to exist. Contrary to the "continuity of control" doctrine embodied in PM A-00-76, the Board finds that such an interpretation of the related party regulation is not only inconsistent with the regulation governing consolidations, but it also ignores the very nature of a consolidation. A combination of entities would likely result in some overlap of membership on the boards of trustees of the consolidating corporations and the new entity, as well as a continuation of other operations and personnel of the old organizations. The fact that this occurs does not disqualify a consolidation from revaluation under 42 C.F.R. §413.134(1) and recognition of any gain or loss. 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 entity was permissible.

The Board acknowledges the CMS Administrator's reversal of the Board majority's decision in *Cardinal Cushing Hospital/Goddard Memorial Hospital*[24] involving virtually identical circumstances. Based upon his review of the related party regulations, 42 C.F.R. §413.17 and HCFA Ruling 80-4, the Administrator concluded that the record

---

[21] Exhibit P-15.

[22] Exhibit P-8.

[23] Exhibit P-56.

[24] *See also* Board and CMS Administrator decisions in *St. Joseph, supra*.

contains compelling evidence of the relatedness of the consolidating corporations and the newly established corporation. However, since the issue under appeal concerns the recognition of losses on the transfer of assets resulting from a consolidation, the Board cannot limit its review only to the related party rules, but it must also view the transaction in light of the specific consolidation regulations at 42 C.F.R. §413.134(1)(3).

The Board found in *Cardinal Cushing Hospital/Goddard Memorial Hospital*,[25] as it does in the instant case, that the explicit language in the consolidation regulation severely limits the application of the related party regulations to consolidations. The Board also found that the related party principles, if applied as the Intermediary and Administrator assert, would emasculate the consolidation regulation. The Board finds nothing in the Administrator's reversal of *Cardinal Cushing Hospital/Goddard Memorial Hospital* that reconciles the competing principles expressed in the two regulations. For example, the Administrator's decision cites Internal Revenue Service (IRS) precedent for the proposition that a consolidation is merely a reorganization, and thus, a gain or loss is not recognized for IRS purposes.[26] The Administrator's decision does not address what characteristics convert a consolidation, executed strictly according to state law and precisely fitting the Medicare regulation's description of consolidation, into a mere reorganization. The Board observes that all consolidations and mergers are to some extent a form of reorganization as that term may be commonly used.[27] CMS was undoubtedly aware of the nature of these transactions when the regulations and guidelines were developed. CMS, nevertheless, distinguished transactions that would result in a depreciation adjustment by whether the constituent corporations were related. The Board finds that distinction is significant and binding as to whether the Provider is entitled to recognition of a loss on the disposition of their depreciable assets.

The 10th Circuit Court of Appeals in *Via Christi, supra,* likewise found the Secretary's attempt to apply the continuity of control concept unsupportable given the explicit language of the consolidation regulation, finding that "we cannot torture the language to reach the result the agency wishes." Citing *Aspenwood Inv.,Co.,* 355 F.3d at 1261. However, the court in *Via Christi* does agree with the Secretary's position that, even if a gain or loss is authorized by the regulation, the Provider nevertheless has an additional burden of showing that the transaction constitutes a "bona fide sale." It stated:

---

[25] See also the Board's decisions in *AHS 96 Related Organization Costs Group Appeal v. Blue Cross and Blue Shield Association/Riverbend Government Benefits Administrator*, PRRB Dec. No. 2003-D34, June 27, 2003 rev'd CMS Administrator, Aug. 20, 2003, Medicare & Medicaid Guide (CCH) ¶81,083 and *Meridian Hospitals Corporation Group Appeal v. Blue Cross and Blue Shield Association/Riverbend Government Benefits Administrator*, PRRB Hearing Dec. No. 2003-D35, July 2, 2003, Medicare & Medicaid Guide (CCH) ¶81,021, *rev'd* CMS Administrator, Aug. 19, 2003, Medicare & Medicaid Guide (CCH) ¶81,082.

[26] The Administrator acknowledges that Medicare reimbursement rules diverge from IRS rules, and Medicare policy is not bound by IRS' policy.

[27] In reversing the Board's decision in *Cardinal Cushing/Goddard Memorial Hospital*, the Administrator points out, in footnote 11, that Massachusetts State Law appears to recognize mergers and consolidations as forms of reorganization.

> We agree with the Secretary that, in order for consolidating Medicare providers to obtain reimbursement for a depreciation adjustment, the consolidation must meet the "bona fide sale" requirements of 42 C.F.R. §413.134(f). As with the "related parties" determination, the Secretary's interpretation of the regulations here is "controlling . . . unless it is plainly erroneous or inconsistent with the regulation," and we must defer to it "unless an alternative reading is compelled by the regulation's plain language or by other indications of the Secretary's intent at the time of the regulation's promulgation." *Thomas Jefferson Univ*., 512 U.S. at 512 (citations and internal quotation marks omitted).

Via Christi at 1259.

The circuit court failed to address the preamble to the regulation's promulgation as a significant indication of the Secretary's intent. We find that the preamble's use of the term "bona fide transaction"[28] versus "bona fide sale" indicates that the Secretary did not consider mergers and consolidations as sales and was only concerned that the transaction was not a sham. The Board is persuaded that the use of the term "bona fide transaction" even though the regulation had a specific section entitled "bona fide sale or scrapping" should not be ignored. See, 42 C.F.R. §405.415(f)(2)(1979). The Board agrees with the parties' stipulation number 5 that this was a "bona fide transaction."

The Board has consistently rejected the position that requires the transaction to be a "bona fide sale," finding instead that when the regulation was amended to add 42 C.F.R. §413.134(l), it expanded the disposition methods listed in section (f) to include consolidations and mergers; it did not require fitting consolidations and mergers into one of the disposition methods already listed. Moreover, to do otherwise fails to consider the distinctive features of a consolidation transaction. By definition, Via Christi is nothing more than a combination of the two hospitals. 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 "arm's-length" would effectively nullify the regulation's directive to permit revaluation where unrelated parties consolidate. The Intermediary's imposition of additional requirements is not supported by the plain meaning of the consolidation regulation and CMS' own previous interpretations set forth in the manual instructions and informal written advice. The Board's conclusion is supported by the commentary in the Federal Register when section 413.134(l) was promulgated. 44 Fed. Reg. 6912, 6913 (Feb. 5, 1979).

The record is clear that the Provider was not interested in selling its assets. Rather, the Provider saw a distinct need to establish a partnership within the health care industry to help assure their continued operation. Testimony elicited at the hearing shows that the Providers were facing a reduction in their revenues that would likely turn to a decline in profitability in the future unless they could better manage the health care market's overall

[28] See, Exhibit P-15, 44 Fed. Reg. page 6913.

inpatient capacity to managed care levels through merger, consolidation, or some other type of transaction.[29]

The Provider argues that the liabilities assumed by Via Christi for the two hospitals' assets establish the consideration that is to be used as the acquisition cost. The Provider further contends that the acquisition cost resulted from arm's-length bargaining among unrelated consolidating parties, and thus, reflects the fair market value of the transaction. Accordingly, the Provider concludes that the revaluation of the assets and calculation of the loss is purely a function of allocating the consideration (liabilities assumed) among all of the assets transferred.[30]

A fundamental principle of Medicare reimbursement requires that the cost of covered services be reasonable and necessary and be determined in accordance with regulations promulgated by the Secretary. Reimbursement consequences of any transaction must ultimately be tested in light of this principle. The Provider, though consolidated under a new corporate structure, continued providing many of the same services using the same facilities and, to some extent, using the same personnel.[31] The Board recognizes that, if this transaction had been structured as a sale with the old providers creating their own buyer and dictating the terms, a loss would not have been recognized because it would have been treated as being between related parties. Related party rules and regulations prohibit "self-dealing" to obtain reimbursement from the Medicare program. The writers of the consolidation regulation did not address why CMS adopted a different policy for statutory mergers and consolidations. However, the regulatory history discussed above demonstrates that CMS thoroughly considered application of related party principles to consolidations and required that such a transaction be deemed to be between unrelated parties if the consolidating entities were unrelated, even if a purchase and sale of assets that might lead to a similar end result could require a different conclusion under other Medicare regulations.

The Board acknowledges that there was no "disposition" of assets as that term is used in the specific regulatory provision addressing gains and losses on disposal of assets. However, the Board has previously concluded that the consolidation regulation, as written, insulates the application of the principles concerning "bona fide sale" and "arm's- length bargaining" to the relationship between the consolidating hospitals. Given

---

[29] April 25, 2007 Transcript (Tr.) at 60-66.

[30] 42 C.F.R. § 413.134(f)(2)(iv) provides that: "[i]f 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.

[31] Lack of disposition was also a factor in the Administrator's reversal of the Board in *Cardinal Cushing Hospital /Goddard Memorial Hospital*, quoting a court decision that said "[n]o substantial change has been affected (sic) either in the nature or substance of the taxpayer's capital position . . . ." In this matter, the two consolidating hospitals would permit joint strategic planning, economies of scale and better competitive position based on their market share. *See* Exhibits P-29, P-33 at 21-34, Tr. at 65, 200-203, *see also* Exhibit P-1, master Plan of Consolidation at 1-2.

the regulation's explicit limitation on the application of the related party principle and CMS' long-standing interpretation that the regulation addressing consolidations applies to non-stock company transactions, the Board 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.

Pursuant to long-standing Medicare reimbursement policy, the ultimate goal of reimbursing depreciation is to compensate a provider for the cost of providing care to Medicare patients. When ownership of depreciable assets changes, cost 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. In a consolidation, however, the terms are dictated by operation of law and there is typically no "consideration" other than the amount of liability assumed.[32] The Board is, nevertheless, bound by the regulation's directive to adjust depreciation when unrelated Medicare providers engage in a consolidation.

The Board concludes that evidence of a changing healthcare environment, combined with the lack of a market for provider facilities, is persuasive that the Provider incurred a genuine economic loss of value of its depreciable assets.

The Board further concludes that the process of finding a suitable consolidation partner requires arm's-length evaluation and bargaining similar to that in a traditional sale, although the Board believes it may be imprecise in producing fair market value. CMS Pub. 13-4 §4508.11 supports this view. Accounting Principles 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."[33] APB No. 16 contains a comprehensive discussion of the advantages and disadvantages and the practical difficulties of treating a combination as a purchase. 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 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

[32] The Board notes that the greater the difference between the book value of assets and the liabilities assumed, the more difficult the application of typical allocation methodologies becomes. 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 floundered, 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 Corporation A and recouping a gain on the poor performing Corporation B.

[33] The manual cautions, though that: "[i]n certain areas, Medicare policy deviates from that in generally accepted accounting principles. Refers to principles outlined in this chapter which specify when reference to APB No. 16 is in accordance with current Medicare policy."

combination recognize primarily the bargained values and only secondarily the costs of assets and liabilities carried by the constituents. . . ."

Despite the lack of nexus between liabilities assumed and fair market value, using liabilities assumed as the acquisition cost is supported by the 1987 letter written by HCFA's Director of the Division of Payment and Reporting Policy, Office of Reimbursement Policy.[34] It stated, in relevant part:

> [i]n a situation where the surviving/new corporation assumes liability for outstanding debt of the merged/consolidated corporations, the assumed debt would be viewed as consideration given. Thus, in a merger or consolidation of nonstock, nonprofit corporations in which the surviving or new corporation assumes debt of the merged or consolidated corporations, the basis of the assets in the hands of the surviving or new corporation would be the lesser of the allowable acquisition cost of the assets to the owner of record as of July 18, 1984 (gross book value), or the acquisition cost of the assets (amount of the assumed debt) to the new owner (the surviving or new corporation). In addition, an adjustment to recognize any gain or loss to the merged/consolidated corporations would be required in accordance with regulations section 42 C.F.R. §413.134(f). For purposes of calculating the gain or loss, the amount of the assumed debt would be used as the amount received for the assets, notwithstanding any limitation on depreciable basis imposed on the surviving/new corporation.

In a letter dated August 24, 1994, HCFA's Director, Office of Payment Policy, Bureau of Policy Development,[35] agreed that a consolidation as defined in 42 C.F.R. §413.134(1)(3)(i) required a determination of a gain or loss under 42 C.F.R. §413.134(f). With respect to the apportionment of the sale price, the letter stated the following:

> [w]ithin the context of Medicare payment policy, generally accepted accounting principles (GAAP) are recognized only when a particular situation is not addressed in the regulations. Because the allocation of purchase price is addressed in both a regulation and in the instructions, GAAP (APB-16) would not apply. The regulations at 42 C.F.R. §413.134(f) (2) (iv) and §104.14 of the Provider Reimbursement Manual, require that when more than one asset is sold 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 relative fair market value of each asset. The allocation must be to all assets and must be proportionate to their relative fair market value. In the situation you described, since the sales price was a lump

[34] Exhibit P-8.
[35] Exhibit P-56.

> sum and the fair market value exceeds the sales price, the sales price must be apportioned among all the assets transferred proportionate to their relative fair market value.

(Emphasis in original).

The Board concludes that the assumption of liabilities through a consolidation transaction is persuasive evidence of acquisition costs. Liabilities assumed in a consolidation also may, but do not necessarily, equate to fair market value.

The Board also finds that the Provider agrees that the loss calculation should be based upon the proportionate value methodology prescribed by 42 C.F.R. §413.134(f)(2)(iv). Pursuant to this methodology, the consideration at issue, the amount of assumed liabilities, is allocated among all of the assets transferred based upon the relationship of each asset's fair market value to the total fair market value of all of the entity's assets in the aggregate.

Even though the Board adheres to its decision that meeting the 'new' definition of a *bona fide* sale is not required, it also recognizes that courts in other cases have found the Secretary's position supportable. In the interest of judicial economy, the Board will therefore address application of that principle to the facts in this case.

At the time of the subject transaction, there was no definition in the regulations or manual instructions for a "bona fide sale as referred to in 42 C.F.R. §413.134(f)(2)." However, 42 C.F.R. §413.134(b)(2) addressed *bona fide* sale in the context of defining fair market value, as follows:

> [f]air 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.

Based upon the above definition, it appears that two things are needed for a *bona fide* sale. First, there must be bargaining between a well-informed buyer and seller. Second, there is an assumption that the results of the bargaining would approximate fair market value. The Board finds that in a consolidation there is no buyer and seller as contemplated in the regulation. Rather, each of the consolidating parties is in essence both a "seller" and a "buyer" (even though the buyer does not exist prior to the transaction) thus negating the concept of arm's-length bargaining.

Under the regulatory definition of a consolidation, all liabilities and assets of the consolidating parties are assumed by the new entity. The liabilities assumed are then the consideration paid for the assets. In *Via Christi*, the court indicated that if the 'bona fide sale' criteria can be met, further analysis is still required to assure that the consideration paid is reasonable; that is, it approximates fair market value. The Board notes that an appraisal is a third party's attempt to derive the price that arm's length bargaining should

produce. The appraisal in this case by Valuation Counselors states that "[t]his valuation was undertaken for the purpose of determining the fair market value as of September 30, 1995, of the business enterprise and the tangible assets of the [St. Francis Regional] medical center in conformity with Medicare regulations"[36] The appraiser determined that the income approach was best suited for the hospital disposition and concluded that the fair market value for all St. Francis' assets was $219 million. The consideration paid, that is the liabilities assumed, was $212 million.[37] Therefore, the Board finds that the amount paid *approximates* the fair market value of the assets, even though this correlation is purely coincidental in the consolidation context.

DECISION AND ORDER:

The Intermediary's adjustments disallowing the Provider's claimed loss on the disposal of assets due to a change of ownership resulting from a consolidation were contrary to the regulatory requirements of 42 C.F.R. §413.134(l)(3)(i) and are reversed. The matter is hereby remanded to the Intermediary for the proper calculation of the loss pursuant to the governing regulatory and manual provisions.

Board Members Participating:

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

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

DATE: July 8, 2009

[36] Exhibit P-37 at 1.
[37] Exhibit P-101. (Net of PMA Book Value).