PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

2004-D38

PROVIDER –
Saint Clare's Hospital - Dover

Provider No. 31-0067

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Riverbend Government Benefits
Administrator

DATE OF HEARING –
April 10, 2003

Cost Reporting Period Ended
September 30, 1994

CASE NO. 02-1971

INDEX

ISSUE:

Was the Intermediary's determination of loss on consolidation proper?

GOVERNING STATUES AND REGULATIONS:

This dispute arises out of Riverbend Government Benefits Administrator's (Intermediary) reopening of Dover General Hospital and Medical Center's (now operated as Saint Clare's Hospital – Dover) (Dover or Provider) fiscal 1994 Medicare cost report to disallow adjustments to depreciation that the Provider claims are due under the Medicare program (42 U.S.C. §1395 et seq.) on a reasonable cost basis for the 1994 fiscal year. The amounts in contention relate to a claimed loss stemming from a consolidation between Dover and Saint Clare's Riverside Medical Center (Saint Clare's) to create a new entity, Northwest Covenant Healthcare System (Northwest).

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)[1] of the Department of Health and Human Services is 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 incurred during the fiscal year and what proportion of those costs are 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 NPR. See 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 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 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 reimbursed on an annual basis for a percentage of the yearly depreciation equal to the percentage the asset was 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 disposed of by the provider for less than the net 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 disposal price was less than the estimated remaining value. In that event, the Secretary assumes

[1] HCFA is now known as the Centers for Medicare and Medicaid Services (CMS). Because many of the documents relied on refer to HCFA, the Board has used HCFA throughout this decision.

that more depreciation had occurred than was originally estimated and accordingly provides additional reimbursement to the provider. Conversely, if the asset is disposed of 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).

The Provider contends that its consolidation with Saint Clare's to form the new entity, Northwest, 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 services to Medicare beneficiaries. The Provider alleges that the Intermediary's determination denying the loss on disposition of assets in connection with the consolidation of the two facilities was incorrect.

STATEMENT OF FACTUAL AND PROCEDURAL HISTORY:

The majority of pertinent facts in this case have been stipulated by the parties and are summarized as follows:

Prior to the date of the consolidation (October 1, 1994), Dover and Saint Clare's were wholly unrelated hospitals independent of one another. Saint Clare's was operated as a Catholic hospital subject to the Ethical and Religious Directives of the Catholic Health Care Services.[2] Dover was operated as a community-based nonprofit hospital with no religious affiliations.[3] The hospitals were competitors and vied for patients in the same general geographic area.

In 1993, the health care market in New Jersey underwent a significant change when New Jersey deregulated the hospital industry. For the first time, each hospital was required to compete in an open marketplace without the benefit of price supports.[4] Deregulation also led to a significant increase in the penetration of the New Jersey health care market by managed care payors, which markedly reduced the amount of reimbursement to New Jersey hospitals.[5] Dover, with an aging and outdated facility serving an economically disadvantaged community, struggled in this new environment, posting an operating loss in the second half of 1993.[6] Attempting to service its debts and remain economically viable, Dover approached Saint Clare's about the possibility of a business combination.[7] Although financially healthy, Saint Clare's saw distinct advantages to a combination with Dover in terms of an expanded service area and greater market penetration, all of which would improve its position in negotiating and obtaining managed care contracts.[8]

In mid-1993, the Boards of Trustees of Dover and Saint Clare's each voted to form a joint task force to study whether a combination of the two entities would enable the institutions to better serve their respective communities.[9] In September 1993, the joint task force recommended

[2] Stip. 5; Tr. 85.
[3] Stip. 6; Tr. 85.
[4] Tr. 86-89.
[5] Id.
[6] Tr. 91-92.
[7] Tr. 93-96, 101-102.
[8] Id.
[9] Provider Exhibit P-1; Tr. 102.

consolidating the two entities to form a new health care system.[10] On September 29, 1994, each board adopted appropriate resolutions, and a consolidation agreement was consummated effective October 1, 1994.[11] As a result of the consolidation, Dover and Saint Clare's were consolidated into Northwest, which was concurrently incorporated on October 1, 1994.[12] Through this transaction, Dover transferred its assets in exchange for the assumption of its liabilities, amounting to a "purchase price" of approximately $67 million.[13]

Both Dover and Saint Clare's ceased to exist as separate corporations upon consolidation.[14] Dover's sole corporate member, Lake Area Health System, also ceased to exist.[15] After consolidation, Northwest operated both hospitals under common management.[16] The Northwest Board of Directors initially included 42 board members composed of 21 former Dover board members and 21 former Saint Clare's board members.[17] Within one year, the Northwest board was reduced to 30 members (15 from each pre-consolidation entity).[18] After that, as their terms expired, the Northwest board members were replaced with new members, and no effort was made to preserve balance between the pre-consolidation entities.[19] By 2002, all of the former Saint Clare's and Dover board members had been replaced.[20]

Upon execution of the consolidation, the sole corporate member of Northwest was the Sisters of the Sorrowful Mother (Sisters), the same entity that had served as the corporate member of Saint Clare's.[21] The Sisters retained substantial reserve powers over the operation of Northwest.[22]

In filing its terminating Medicare cost report, Dover initially did not claim a loss on the disposition of its assets.[23] By an agreement prior to the issuance of the initial NPR, however, the fiscal intermediary considered the loss on consolidation issue.[24] The fiscal intermediary allowed the loss after discussing the issue with HCFA

In calculating the amount of the loss, rather than following generally accepted accounting principles (GAAP) as outlined in the Medicare Intermediary Manual, the Intermediary, as

[10] Provider Exhibit P-2; Tr. 102-104.
[11] Provider Exhibit P-8; Tr. 104-105.
[12] Provider Exhibit P-8.
[13] Provider Exhibits P-8 and P-16; Tr. 357-358.
[14] Provider Exhibits P-6 and P-8; Tr. 115-116.
[15] Stip. 8.
[16] Provider Exhibit P-8.
[17] Provider Exhibit P-8; Tr. 106.
[18] Tr. 106, 505-506.
[19] Tr. 163-164.
[20] Tr. 163.
[21] Provider Exhibit P-8; Stip. 7.
[22] Stip. 9; Tr. 110.
[23] Tr. 348.
[24] Stip. 13; Tr. 348-350, 444-445.

directed by HCFA, utilized a hybrid methodology, having some elements of GAAP and some of a "proportional allocation" methodology.[25]

In 2000, HCFA instructed the Intermediary to reopen the Provider's 1994 Medicare cost report to reconsider the amount allowed, which subsequently led HCFA to instruct the Intermediary to disallow the loss in its entirety.

The Provider was represented by Irwin Cohen, Esquire, of Fulbright & Jaworski, L.L.P. The Intermediary was represented by Eileen Bradley, Esquire, of the Blue Cross and Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that its transaction with Saint Clare's was a consolidation that resulted in a loss on the disposal of assets under the relevant Medicare regulations. In 1977, HCFA published a proposed regulation which listed certain transactions that would trigger revaluation. The proposed rule specifically prohibited the revaluation of assets in the event of a consolidation. In 1979, however, HCFA reversed its proposed policy and promulgated a final rule that explicitly recognized that consolidations between unrelated parties would create a basis for a revaluation of assets. The change of ownership provisions ("CHOW") in the Medicare Intermediary Manual further confirm HCFA's policy that consolidations would trigger a revaluation of assets and the recognition of a gain or loss.

Contrary to the Intermediary's assertions, which were based on a Program Memorandum published on October 19, 2000 (Transmittal No. A-00-76) ("Program Memorandum"), the Provider argues that the consolidation was not between related parties, since the parties were not related prior to the consolidation as contemplated by the applicable Medicare regulations. In addition, the Provider, while rejecting the Intermediary's position that the bona fide sale requirements should apply to the consolidation, nevertheless contends that the transaction met all of the requirements of a bona fide sale.

The Intermediary argues that the Provider is not entitled to claim the loss for two principal reasons. First, the Intermediary contends that the transaction between the Provider and Saint Clare's was between related parties, thereby violating Medicare regulations. The Intermediary argues that the Provider exercised control over Northwest, citing among other things: 1) the super-majority provision in the consolidation agreement; 2) a provision regarding potential dissolution of assets; and 3) the fact that certain management personnel were left in place at each facility (on an interim basis) following the consolidation. Second, the Intermediary concludes that the transaction did not meet the Medicare definition of bona fide sale.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION

The Board, after consideration of the parties' contentions and the evidence presented, finds and concludes that the Provider was unrelated to Saint Clare's, the other party to the consolidation, as

[25] Tr. 528-531, 534-535.

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 recognition of gain or loss incurred as a result of the consolidation is required under the specific and plain meaning of 42 C.F.R. §413.134(l)(3)(i).

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.[26] Section 413.134(1) defines a consolidation as "the combination of two or more corporations resulting in the creation of a new corporate entity."[27] It is undisputed that the Provider was formed through the consolidation of two hospitals into one new entity, with the two pre-existing entities ceasing to exist. Under the terms of the transaction, Northwest acquired all of the assets and assumed all of the liabilities associated with the operation of the two pre-existing entities.

The Medicare regulation at 42 C.F.R. §413.134(1)(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.

The first question to be decided by the Board is, therefore, whether the consolidation was between unrelated parties. It is undisputed that Dover and Saint Clare's 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. The Intermediary points to the related party regulation at 42 C.F.R. §413.17, which states, in pertinent part:

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[26] 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 1986 letter that the regulation applied to consolidations of nonprofits. See Providers' Legal Authorities Exhibit G. 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 Nonprofit Providers," HCFA Program Transmittal A-00-76, states that the regulation applies to nonprofits; however, "special considerations" apply. See Provider's Legal Authorities Exhibit V.

[27] See Cardinal Cushing Hospital/Goddard Memorial Hosptial 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, for a thorough discussion of the Board's view of consolidation on facts similar to those in this case.

> (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.
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> (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 the new entity was composed of board members of the two consolidating entities, there is a "continuity of control" that results in Dover and Saint Clare's each being related to the new corporation, Northwest. The Intermediary contends that this relationship between the old and new entities disqualifies the transaction from revaluation of assets. In support, the Intermediary cites an October 19, 2000 HCFA Program Memorandum entitled "Clarification of the Application of the Regulations at 42 C.F.R. §413.134(1) to Mergers and Consolidation Involving Nonprofit Providers." The October 2000 Program Memorandum states, in part:

> 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 HCFA's purported "clarification" and is dispositive of the Intermediary's argument. The text clearly provides that "if the consolidation is between two or more corporations that are unrelated," the related party concept will not 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 (1) 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 Fed. Reg. 17486 (April 1, 1977).

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).

Accordingly, the Board concludes that the plain language of the regulation bars application of the related party principle to a consolidating party's 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's conclusion is further buttressed by the Secretary's interpretive guidelines published in the Manual long before the October 2000 "clarification." HCFA Pub. 15-1 §4502.7 states, in part, with regard to consolidation, "Medicare program policy permits a revaluation of assets affected by corporate consolidations between unrelated parties."

Further indication of HCFA'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,[28] 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 consolidation of not-for-profit hospitals. The conclusion of this letter was that a consolidation among not-for-profit providers gives rise to the revaluation of assets. The letter also made it clear that, notwithstanding the reference to "capital stock" in the caption of the regulation, 42 C.F.R. §413.134(k),[29] HCFA looked to that regulation for authority in addressing mergers and consolidations of non-stock issuing corporations because the principles involved would be the same.

The Board finds that the transaction that resulted in the formation of Northwest was a bona fide transaction under New Jersey corporation law. The completed transaction consolidated two independent hospital corporations into one new entity, with the two pre-existing entities ceasing to exist. Contrary to the "continuity of control" doctrine embodied in the HCFA Program Transmittal A-00-76, dated October 19, 2000, 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 directors of the consolidating corporations and the new entity, as well as a continuation of other operations and personnel of the old organization. The fact that this occurs does not disqualify a consolidation from revaluation under 42 C.F.R §413.134(1). 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.

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[28] See Provider's Exhibit P-15.

[29] The letter actually references subsection (k) but it is the caption on subsection (l) that says: "Transactions involving a provider's capital stock."

With respect to the Intermediary's argument that the relationship between the Provider, St. Clare and Northwest does not meet the traditional test of "bona fide" and "arm's length" bargaining, the Board finds that the application of such criteria fails to consider the distinctive features of a consolidation transaction. By definition, Northwest 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 HCFA's own previous interpretation set forth in the manual instructions and informal written advice.

The Board acknowledges the CMS[30] Administrator's reversal of the Board majority's decision in Cardinal Cushing Hospital/Goddard Memorial Hospital v. Blue Cross and Blue Shield Association/Associated Hospital Services of Maine, ("Cushing/Goddard")[31] 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 contains compelling evidence of the relatedness of the consolidating corporations and the newly established corporation.

The Board agrees with the Administrator that if a consolidation is viewed only in light of the related party regulations and guidelines, a consolidation appears to be a related party transaction in that the consolidating parties create their successor and determine how it will operate, at least initially.[32] We also agree that the "continuity of control" concept discussed in HCFA Program Transmittal A-00-76 dated October 19, 2000, is fairly encompassed in the related party rules as they existed prior to the issuance of the Program Memorandum to Medicare Intermediaries. Whether or not "continuity of control" is a new concept is irrelevant. 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 Cushing/Goddard,[33] 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

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[30] Formerly known as HCFA Administrator.

[31] Cardinal Cushing Hospital/ Goddard Memorial Hospital v. Blue Cross and Blue Shield Association/Associated Hospital Services of Maine, PRRB Dec. No. 2003-D6, November 27,2002, Medicare and Medicaid Guide (CCH) ¶80,950, rev'd, CMS Administrator, January 29, 2003, Medicare & Medicaid Guide (CCH) ¶ 80,975. See also St. Joseph Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Kansas, PRRB Dec No. 2003-D64, September 29, 2003, Medicare and Medicaid Guide (CCH) ¶ 81,020, rev'd, CMS Administrator, Nov. 25, 2003, Medicare & Medicaid Guide (CCH) ¶ 81,092.

[32] As discussed infra the writers of the original proposed regulation took the same view but that position was reversed through the rulemaking process.

[33] 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

consolidations. The Board also found that the related party principles, if applied as the Intermediary and Administrator assert, would emasculate the consolidation regulations. The Board finds nothing in the Administrator's reversal of Cushing/Goddard 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.[34] 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 a large extent a form of reorganization as that term is commonly used.[35] HCFA was undoubtedly aware of the nature of these transactions as reorganizations when the regulations and guidelines were developed. HCFA, nevertheless, distinguished transactions that would result in a depreciation adjustment only by whether the constituent corporations were related. The Board finds that limited distinction significant and binding as to whether the Provider is entitled to a revaluation of its depreciable assets.

The Provider argues that the liabilities assumed by Northwest 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, approximates 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 acquired.[36]

In contrast, the Intermediary relies on the October, 2000 "Clarification" and cites the lack of motivation to maximize the sales price of depreciable assets to support denying reimbursement of the loss claimed by the Provider. The gain/loss regulation was not amended when the additional sections on consolidation and merger were added. The old sections clearly contemplate that an "acquisition cost" will have been determined through bona fide, arm's length bargaining typical of a sale that is likely to produce fair market value.

A fundamental principle of Medicare reimbursement requires that the cost of covered services be reasonable and necessary. Reimbursement consequences of any transaction must ultimately be tested in light of this principle. The treatment of this transaction as a sale that would trigger a gain or loss calculation is especially perplexing because the Providers, though consolidated

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Administrator, August 20, 2003, Medicare & Medicaid Guide (CCH) ¶ 81,021, rev'd CMS Administrator, Aug. 19, 2003, Medicare & Medicaid Guide (CCH) ¶ 81,082.

[34] Administrator's Cushing/Goddard Decision. The Administrator acknowledges that Medicare reimbursement rules often diverge from IRS rules and Medicare policy is not bound by IRS' policy.

[35] The Administrator's Cushing/Goddard Decision, at footnote 11 points out that Massachusetts State law recognizes mergers and consolidations as forms of reorganizations.

[36] 42 C.F.R. §413.134(f)(2)(iv) provides that: "[i]f a provider sells more than one asset for a lump sum sale 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.

under a new corporate structure, continued providing the same services using the same facilities and, to a great extent, using the same personnel.[37] The Board is troubled 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 failed to provide any reconciliation among the various regulations that may apply to these types of transactions. HCFA must, therefore, accept some responsibility for this quagmire.

The Board acknowledges that there was no "disposition" of assets as that term is used in the regulation on gains and losses. However, the Board has previously concluded that the consolidation regulation, as written, insulates the application of the principles concerning "bona fide" and "arm's length bargaining" to the relationship between the consolidating hospitals and their successor. Given the explicit limitation on the application of the related party principle and HCFA's long-standing interpretation that the regulation 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 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. 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.[38] The Provider submitted the testimony of two ex-HCFA officials, both of whom were represented as having had an integral role in the policy development of the consolidation regulations and guidelines. 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.

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[37] Lack of disposition was also a factor in the Administrator's Cushing/Goddard Decision "[n]o substantial change has been affected (sic) either in the nature or substance of the taxpayer's capital position . . . ."

[38] 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 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 Corporation A and recouping a gain on the poor performing Corporation B.

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. The Medicare Intermediary Manual supports this view. CMS Pub. 13-4 § 4508.11 incorporates, as part of the Manual, 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." Id.[39] 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 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. It stated:

> In 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.[40]

In a letter dated August 24, 1994,[41] HCFA's Director, Office of Payment Policy, Bureau of Policy Development, agreed that a consolidation as defined in 42 C.F.R. §413.134(1)(3)(i)

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

[40] See Provider's Position Paper at Provider's Exhibit P-15.

[41] See Provider's Position Paper at Provider's Exhibit P-14.

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:

> Within 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 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.

With respect to the calculation of the loss resulting from this consolidation, the Intermediary now maintains that the loss claimed by the Provider should not be recognized. Although the Intermediary previously allowed the loss and discussed the methodologies associated with the calculation of the loss at the hearing, it did not present any meaningful discussion in a post-hearing brief.

In evaluating the calculation of the loss, the Board has considered various allocation methodologies, the applicable governing authorities, and the evidence presented. It is the Board's conclusion that the acquisition cost, i.e., the amount of assumed liabilities must be prorated among the Provider's assets transferred using the proportionate value method set forth in 42 C.F.R. §413.134(f)(2)(iv). The manual provisions at CMS Pub. 13-4 §4506, entitled "Revaluation of Assets and Gain/Loss Computation," provide further guidelines for applying the allocation procedures under this methodology.

The Provider proposed to use the purchase allocation method following GAAP by using the purchase allocation method set out in APB 16 that assigns the purchase price to all assets including intangibles. The intangibles identified by the Provider include medical records, assembled work force, medical library, radiology films and in-place procedures.[42] The

[42] See Provider Exhibit 11 at 105.

Intermediary in its original determination allowing a loss did not permit an allocation to intangible assets.[43]

Of the intangible items claimed, the Board finds that the medical library and its related material, are, in fact, tangible assets and only their value should be reflected as an asset in the loss calculation and receive an allocation. The Board finds guidance for this matter in Paragraph 39 of the Financial Accounting Standards Board's (FASB) Statement 141, Business Combinations. In general, FASB explains that intangible assets, which did not arise from contractual rights, shall be recognized as assets apart from goodwill only if they are capable of being separated from the acquired entity and sold, transferred, licensed, rented or exchanged. The Board finds that the Provider's medical records, radiology film, and assembled workforce did not arise from contractual rights, and further, that these items are not capable of being separated and sold, transferred, etc., from the Provider's other assets.

The consolidated hospital operations continued without interruption. Therefore, in applying Paragraph 39, the question becomes whether the Provider could have parted with (sold, rented, transferred, etc.) its medical records, radiology film, and workforce while in business treating patients. The Board finds it unrealistic for an established operating hospital to part with these items or with the bulk of its personnel. The Board concludes that the same rationale applies to medical records and films in that they, too, are inseparable from an ongoing hospital operation. Medical records are relied on by administrative personnel for billing purposes, and both medical records and radiology film are relied on by nursing and physician personnel for hands on patient care. Notably, Paragraph 39 specifically states:

"[f]or purposes of this Statement, an assembled workforce shall not be recognized as an intangible asset apart from goodwill."

Finally, the Board finds that intangible assets have value only when the total value of an entity, in its entirety, exceeds the value of its net tangible assets. This condition is not present in the instant case where the consideration received by the Provider was less than the value of its tangible assets and resulted in a loss.

DECISION AND ORDER:

The Intermediary's adjustments disallowing the Provider's claimed loss on 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(1)(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 and consistent with the Board's findings concerning allocation to intangibles.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.

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[43] Tr. at 452.

Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

DATE: September 13, 2004

FOR THE BOARD:

Suzanne Cochran
Chairman