PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D19

PROVIDERs -
Sewickley Valley Hospital and
The Medical Center, Beaver, PA

Provider Nos.: 39-0037 and 39-0036

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/
Veritus Medicare Services

DATE OF HEARING -
March 15, 2005

Cost Reporting Period Ended -
October 31, 1996

CASE NOs.: 99-3470 and 99-3471

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ISSUE:

Whether the Intermediary's denial of a loss on disposition of assets due to a consolidation of Sewickley Valley Hospital and The Medical Center of Beaver was correct.

GOVERNING STATUES AND REGULATIONS**:**

In dispute in these cases is Veritus Medicare Services' (Intermediary) denial of a loss on consolidation of Sewickley Valley Hospital (SVH) and The Medical Center (TMC) into Valley Medical Facilities, Inc. (VMF). The Providers claimed a loss on consolidation in their Medicare cost reports for the fiscal year ended (FYE) October 31, 1996 and maintain that the losses they sustained are allowable under 42 U.S.C. §1395 et seq.

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 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 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 services 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"

[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 and CMS interchangeably throughout this decision.

has occurred, since the disposal price was less than the estimated remaining value. In that event, the Secretary assumes 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 Providers contend that their consolidation formed the new entity Valley Medical Facilities, Inc., (VMF). That transaction, like a sale, resulted in a disposition of assets and gave rise to a loss in which Medicare must share in order to fully reimburse the reasonable costs of providing services to Medicare beneficiaries. The Providers allege that the Intermediary's denial of the loss on disposition of assets in connection with the consolidation of the two facilities was incorrect.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Sewickley Valley Hospital and The Medical Center of Beaver and Blue Cross Blue Shield Association jointly stipulated to the facts at Provider Exhibit No. 10. The following is a summary of the relevant facts from that stipulation:

- On October 31, 1996, Consolidated Healthcare Services (CHS) was a Pennsylvania non-profit corporation in Beaver, Pennsylvania, Beaver County, and was the parent-member of The Medical Center (TMC).

- On October 31, 1996, TMC was a Pennsylvania non-profit corporation in Beaver, Pennsylvania, Beaver County and a duly licensed 468-bed acute care general hospital under Pennsylvania law.

- On October 31, 1996, Sewickley Valley Hospital (SVH) was a Pennsylvania non-profit corporation in Pittsburgh, Pennsylvania, Allegheny County and a duly licensed 209-bed acute care general hospital under Pennsylvania law.

- On April 30, 1996, Consolidated Healthcare Services (CHS), TMC and SVH executed an "AGREEMENT OF CONSOLIDATION" (Agreement), which was amended on October 29, 1996.[2]

- The Agreement contemplated the entry through consolidation of TMC and SVH into the yet-to-be-formed corporation, VMF, for which Valley Health Systems (VHS) would become the sole corporate member.

- Prior to the effective date of the statutory consolidation, November 1, 1996 (consolidation date), VMF did not exist.

- VMF, prior to the consolidation date, had neither a board of directors nor corporate officers.

[2] See Intermediary Exhibit I-5.

- At all times prior to the consolidation date, TMC, SVH and VMF did not have a common ownership, common officers or common board members.

- The board of directors and officers of VHS and VMF were identified in the exhibits to the Consolidation Agreement, as amended, but did not take office and had no authority or control over VHS or VMF until the consolidation date.

- Prior to the consolidation date, CHS/TMC and SVH were not related entities and neither was a party to any shared services agreement nor was either a member or party to the same health care delivery system, but all were separate not-for-profit corporations.

- TMC and SVH, prior to the consolidation date, were approved providers participating in the Medicare and Medicaid programs and were in compliance with the conditions of participation in those programs and the provider contracts with those programs.

- Following the closing on October 31, 1996, VMF, the newly formed corporation resulting from the statutory consolidation, succeeded by operation of law to and assumed all rights and obligations of TMC and SVH under the Non-Profit Corporation Law of Pennsylvania.

- On the consolidation date, the assets, liabilities, reserves and accounts of both TMC and SVH were taken upon the books of VMF at the amounts they were being carried on the books of TMC and SVH immediately prior to the closing, subject to any adjustments which were required in accordance with generally accepted accounting principles giving effect to the consolidation date.

- TMC and CHS were represented by outside legal counsel, James C. Tosh, of Beaver, Pennsylvania in the negotiation of the transaction that is the subject of this appeal. SVH was represented by Richard Kotarba of Pittsburgh, Pennsylvania.

- The parties commenced their negotiations in or about November, 1995, culminating in final approvals of the consolidation at board meetings held on October 29, 1996.

- CHS/TMC and SVH independently negotiated the Agreement for over a year.

The following are other relevant facts:

- The governance and control of VMF was granted to VHS, the sole corporate member of VMF. VHS was formed as a result of the corporate reorganization of CHS. Effective November 1, 1996, CHS' articles, bylaws and board were restructured to form VHS. CHS' name was changed to Valley Health System.

- VHS retained certain powers over VMF, including the appointment of the VMF board of directors.[3]

- SVH was organized as a non-membership corporation; as such, the full power, authority and responsibility to govern SVH was vested in its Board of Directors.[4]

- Prior to the consolidation date, SVH had its own Board of Directors, none of whom sat on any of the Boards or Committees of TMC and/or its affiliated entities, including TMC's corporate member, CHS.[5]

- Prior to the consolidation date, SVH had its own executive governing officers, none of whom served in any officer position at or for TMC and/or its affiliated entities, including TMC's corporate member, CHS.[6]

- The consolidation of TMC and SVH was done pursuant to and in conformity with the Non-Profit Corporation Law of Pennsylvania, 15 Pa. C.S.A. §5929 and other related provisions.

- Pursuant to Pennsylvania law, the corporate entities known as TMC and SVH no longer existed following the consolidation.[7]

- The initial board of VHS was composed of twenty (20) directors. Six of these directors had formerly been members of the SVH board, six had formerly been members of the TMC board, six were not members of either the SVH or TMC boards but were chosen as representatives of the local community, and two were *ex officio* members.[8]

- At no time did any of the directors serve simultaneously on both the VHS and TMC or SVH boards since, by operation of law, TMC and SVH, from a corporate governance and structure perspective, went out of existence at the moment VHS was created, none of the directors assumed their positions until the consolidation was effective.[9]

- In exchange for the acquired assets, VMF assumed the liabilities of the Providers. In connection with the transaction, TMC and SVH engaged Valuation Counselors Group (Valuation Counselors), an independent appraiser. Valuation Counselors performed its analysis of the Providers in accordance with Medicare regulations regarding "fair market value."

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[3] See Provider's Final Position Paper at p 6.
[4] See Exhibit P-1, Declaration and Affidavit of Donald W. Spalding, ¶ 6.
[5] See Exhibit P-1, Declaration and Affidavit of Donald W. Spalding, ¶ 10.
[6] See Exhibit P-1, Declaration and Affidavit of Donald W. Spalding, ¶ 11.
[7] See 15 Pa. C.S.A. §5929; see also Exhibit P-1, Declaration and Affidavit of Donald W. Spalding, ¶ 28.
[8] See Hearing Exhibit P-2 Declaration and Affidavit of Donald W. Spalding, ¶ 34
[9] See 15 Pa. C.S.A. §5929; see also Exhibit P-1, Declaration and Affidavit of Donald W. Spalding, ¶ 28.

The Providers appealed the Intermediary's denial of the loss on consolidation to the Board. SVC claimed a loss of $12,489,000. TMC claimed a loss of $13,825,000. The Providers' filings met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Providers were represented by Samuel W. Braver, Esquire, of Buchanan Ingersoll, P.C. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the parties' contentions and the evidence presented, finds and concludes that SVH is entitled to a loss on consolidation, but TMC is not. The Board will first address the loss claimed by SVH and how the amount of the loss is to be recomputed. It will then discuss its findings and conclusions regarding why the loss claimed by TMC will not be allowed. Regarding SVH, the Board finds that it was unrelated to TMC, the other party 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 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.[10] 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."[11] It is undisputed that VMF 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, VMF assumed all of the liabilities associated with the operations 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

[10] 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. 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 Transmittal A-00-76, states that the regulation applies to nonprofits; however, "special considerations" apply.

[11] 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.

> §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 SVH and TMC were not related to one another 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:

> (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 was composed of board members of the two consolidating entities, there is a "continuity of control" that results in the Providers each being related to the new corporation, VMF. The Intermediary contends that this relationship between the old and new entities disqualifies the transaction from revaluation of assets and the concomitant loss on consolidation. In support, the Intermediary cites the October 19, 2000 HCFA Program Memorandum A-00-76 entitled "Clarification of the Application of the Regulations at 42 C.F.R. §413.134(1) to Mergers and Consolidations Involving Non-profit 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.[12]

[12] See Intermediary Exhibit 9, PS.2.

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." Regarding consolidations, HCFA Pub. 15-1 §4502.7 states in relevant part: "Medicare program policy permits a revaluation of assets affected by corporate consolidations between unrelated parties."

The Board finds that the transaction that resulted in the formation of VMF was a bona fide transaction under Pennsylvania 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, 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 organizations. 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.

With respect to the Intermediary's argument that the relationship between SVH, TMC and VMF 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, VMF 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 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)[13] 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.[14] 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

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[13] 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.

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

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,[15] 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 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.[16] 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.[17] 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 Providers are entitled to a revaluation of their depreciable assets.

The Providers argue that the liabilities assumed by VMF for the two hospitals' assets establish the consideration that is to be used as the acquisition cost. The Providers further contend 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 Providers conclude 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.[18]

A fundamental principle of Medicare reimbursement requires that the cost of covered services be reasonable and necessary. Reimbursement consequences of any transaction

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

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

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

[18] 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.

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 under a new corporate structure, continued providing the same services using the same facilities and, to a great extent, using the same personnel.[19] 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 however, 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.[20] 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 Providers incurred a genuine economic loss of value of their depreciable assets.

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[19] Lack of disposition was also a factor in the Administrator's Cushing/Goddard decision, 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 . . . ."

[20] 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 Providers' 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.[21] 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.

In a letter dated August 24, 1994, HCFA's Director, Office of Payment Policy, Bureau of Policy Development, agreed that a consolidation as defined in 42 C.F.R.

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

§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:

> 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.

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.

Regarding the calculation of the loss due SVH, the Provider's final determination was $9,283,094.[22] That amount was based on: (1) excluding certain intangible assets from the calculation, (2) "netting down" current assets as opposed to calculating the loss including current liabilities in the purchase price,[23] (3) using the oldest Medicare utilization versus average Medicare utilization, and (4) excluding bond trustee funds.

The Board responds to each of these inclusions/exclusions as follows.

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[22] See Provider Exhibit P-8.
[23] Tr. at 242-243.

Regarding intangible assets, the Board has decided in prior cases[24] that a portion of the consideration should not be allocated to a provider's intangible assets when computing a loss on consolidation. The Board observes that the SVH's loss computation included an allocation of $1million of the consolidation to VMF for physicians' practice. The Board finds that the loss calculation for SVH should exclude an allocation of consideration to this intangible asset. Regarding the other intangibles in this case, the Provider testified that intangibles were removed from its revised loss calculation presented at Exhibit P-8.[25] However, the details of the amounts were not reflected in the record, although the Provider implied that two specific intangible assets were addressed: assembled workforce and medical records.[26] The Intermediary stated that these items have not been reviewed. Therefore, the Board remands this issue to the Intermediary for a review of all intangible assets to ensure that they are properly excluded from the loss calculation.

Regarding the "netting down" of current assets by current liabilities versus including current liabilities as consideration in the calculation of the loss, the Board finds that the "netting" of current liabilities against current assets defeats the pro-rata allocation required by the Board, by §413.134(f)(2)(iv) and by CMS Pub. 13-4 §4506, discussed above. The inclusion of the current liabilities would significantly reduce the loss claimed by the SVH. The Provider estimates that the loss for SVH would be reduced by approximately $736,100.[27] The Intermediary is directed to audit this calculation for accuracy and completeness.

Regarding the computation of Medicare utilization, the Board notes that the Provider used both the oldest Medicare utilization and the average Medicare utilization in calculating two versions of Medicare's share of the loss claimed.[28] If available, the Intermediary is to use the oldest Medicare utilization to calculate the loss. If that information is unavailable, then the average Medicare utilization should be used after being verified.

Finally, the Board observes that the bond trustee fund was excluded from the loss calculation. However that amount was included on the Provider's (SVH) balance sheet. Since the Board's required pro-rata calculation of the consideration requires all assets and liabilities to be included, the $18,000,000[29] fund should be included. The fact that assets may be dedicated for a specific purpose such as a bond trust fund does not negate their existence.

Regarding The Medical Center of Beaver (TMC) the Board finds that TMC was related to VMF under the related organization principal at 42 C.F.R §413.17. Therefore, the loss claimed by TMC is disallowed in its entirety. As stated in the facts above, the

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[24] See St. Clare Hospital-Dover v. Blue Cross Blue Shield Association/Riverbend Government Benefits Administrator, PRRB Dec. 2004-D38, Medicare and Medicaid Guide (CCH) ¶ 81,191.
[25] Tr. at 219.
[26] Tr. at 218.
[27] See Provider Exhibit P-13.
[28] See Provider Exhibit P-8.
[29] Tr. at 269.

governance and control of VMF, the newly consolidated Provider created on November 1, 1996, was granted to Valley Health System (VHS). The Board notes that VHS was formed as a result of the corporate reorganization of Consolidated Health Services, Inc., the parent corporation of TMC. Effective November 1, 1996, CHS' articles, by-laws and board were restructured to form VHS.[30] The regulation at §413.134(l)(3)(ii) states that if the consolidation is between two or more related corporations as defined by 42 C.F.R. §413.17, no revaluation of provider assets is permitted.

The Board has reviewed the above corporate reorganization of CHS and determined that the control of that organization never really changed. CHS' corporate structure evolved to VHS. It never really changed its identity for related party purposes. It was always related to TMC and was related to the new entity, VMF, when it became operational. For practical purposes CHS/VHS is one and the same. It "acquired" a new subsidiary (VMF) via the consolidation whereby it obtained the assets from its old corporation (TMC). In effect, CHS sold the assets of TMC to itself through the creation of the consolidated corporate provider, VMF. The result was related party relationship through control as defined in 42 C.F.R. §413.17, and Medicare does not allow recognition of the loss in this situation.

DECISION AND ORDER:

Regarding SVC, 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, netting of liabilities, utilization, and trust bond fund. Regarding TMC, the parties (CHS, VHS and TMC) are related under 42 C.F.R. §413.17. As such, the loss on consolidation is denied. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

DATE: February 21, 2007

FOR THE BOARD:

Suzanne Cochran
Chairman

[30] These facts were presented by the Provider in its final position paper at page 6 and are unrefuted.