PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D38

PROVIDER - Polyclinic Medical Center Harrisburg, Pennsylvania	**DATE OF HEARING -** May 16 and 17, 2007
Provider No.: 39-0067	Cost Reporting Period Ended – December 31, 1995
vs.	**CASE NO.:** 00-1454
INTERMEDIARY - Blue Cross Blue Shield Association/ Veritus Medicare Services (n/k/a Highmark Medicare Services)	

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ISSUE:

Whether the Intermediary's adjustments disallowing the loss on disposal of depreciable assets through consolidation were proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

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(b) and 413.24(b).

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:

Polyclinic Medical Center (Provider) was an acute care facility located in Harrisburg, Pennsylvania. Effective December 31,1995 the Provider and Harrisburg Hospital and Seidle Memorial Hospital (Harrisburg/Seidle Hospitals) consolidated to form Harrisburg Polyclinic Medical Center whose name was ultimately changed to Pinnacle Health Hospitals (Pinnacle Hospitals). Pursuant to the terms of the consolidation, Pinnacle Hospitals acquired the Provider's total assets and assumed all of its liabilities. As a result of the transaction, the Provider submitted a terminating Medicare cost report in which it claimed a loss on the disposal of its depreciable assets. The loss was represented by the difference between the net book value of the assets it transferred to Pinnacle Hospitals and the liabilities which Pinnacle Hospitals had assumed. The Intermediary disallowed the claimed loss on disposal of depreciable assets.

The Providers appealed the Intermediary's adjustment 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 $9,938,519.[1]

[1] Intermediary Position Paper at 3.

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 (Exhibit P-127):

1. Prior to the consolidation described in paragraph[2] 12, Harrisburg Hospital was a non-profit corporation that furnished acute care services. Seidle Memorial Hospital was a non-profit corporation that furnished hospital-based skilled nursing facility ("SNF") services. Harrisburg Hospital and Seidle Memorial Hospital had one medical staff, operated under a single hospital license issued by the Commonwealth of Pennsylvania, and were assigned a single Medicare provider number. Seidle Memorial Hospital was treated as a hospital-based SNF on Harrisburg Hospital's cost report. Harrisburg Hospital and Seidle Memorial Hospital were each part of Capital Health System, as described below.

2. Prior to the consolidation described in paragraph[3] 12, Polyclinic Medical Center was a non-profit entity that furnished acute care services. It was part of Polyclinic Health System, as described below.

3. Prior to the consolidation described in paragraph[4] 12, Harrisburg Hospital, Seidle Memorial Hospital, and Polyclinic Medical Center each 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.

4. Harrisburg Hospital, described in paragraph[5] 1, did not have an owner. Harrisburg Hospital's Members were those individuals who comprised Capital Health System Services' governing board.

5. Seidle Memorial Hospital, described in paragraph[6] 1, did not have an owner. Seidle Memorial Hospital's Members were those individuals who comprised Harrisburg Hospital's governing board.

6. Capital Health System Services operated as a non-stock, non-profit corporation. Capital Health System Services' Members were those individuals who comprised Capital Area Health Foundation's governing board.

7. Capital Area Health Foundation ("Capital Foundation") operated as a non-stock, non-profit corporation. Capital Foundation did not have a corporate member.

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[2] Paragraph numbers refer to other paragraphs in the stipulations.
[3] Id.
[4] Id.
[5] Id.
[6] Id.

8. Capital Foundation, Capital Health System Services, Harrisburg Hospital and Seidle Memorial Hospital are referred to herein individually as "Capital Entity," and collectively as "Capital Entities."

9. Polyclinic Medical Center, described in paragraph[7] 2, did not have an owner. Polyclinic Medical Center's Members were those individuals who comprised Polyclinic Health System's governing board.

10. Polyclinic Health System operated as a non-stock, non-profit corporation. Polyclinic Health System's Members were those individuals who comprised Polyclinic Medical Center's governing board.

11. Polyclinic Health System and Polyclinic Medical Center are referred to herein individually as "Polyclinic Entity," and collectively as "Polyclinic Entities."

12. Effective December 31, 1995, Harrisburg Hospital and Seidle Memorial Hospital consolidated with Polyclinic Medical Center. As a result of the consolidation, good title to all of the assets of Harrisburg Hospital, Seidle Memorial Hospital, and Polyclinic Medical Center passed by operation of law to Harrisburg Polyclinic Medical Center, which came into existence as a result of the consolidation. The name of Harrisburg Polyclinic Medical Center was changed subsequently to Pinnacle Health Hospitals (this entity will be referred to as Pinnacle Health Hospitals at all times). Pinnacle Health Hospitals became legally responsible for all of the liabilities of Harrisburg Hospital, Seidle Memorial Hospital and Polyclinic Medical Center, including those which were actual liabilities and reflected on their pre-consolidation financial records, and those liabilities which were contingent or unknown, and which were not reflected on those financial records. As a result of the consolidation, Harrisburg Hospital, Seidle Memorial Hospital, and Polyclinic Medical Center ceased to exist. The transaction was a statutory consolidation under Pennsylvania law 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 consolidation was not a sale of assets, change of sponsorship, a "reorganization" or a donation under applicable provisions of the Internal Revenue Code or under Pennsylvania law. The consolidation was not a sale of assets or change of sponsorship under the Medicare Intermediary Manual or the Provider Reimbursement Manual.

13. The consolidation described in paragraph[8] 12 was consummated pursuant to the Agreement and Plan of Consolidation between and among Harrisburg Hospital, The Seidle Memorial Hospital, and Polyclinic Medical Center of Harrisburg. The Agreement and 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 its form and content was consistent with such agreements negotiated and consummated between arm's-length parties.

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[7] Id.
[8] Id.

14. Concurrent with the consolidation described in paragraph[9] 12, Capital Health System Services consolidated with Polyclinic Health System to create Harrisburg Polyclinic Health System. The name of Harrisburg Polyclinic Health System was changed subsequently to Pinnacle Health System (this entity will be referred to as Pinnacle Health System at all times). The consolidation was consummated pursuant to the Agreement and Plan of Consolidation between Capital Health System Services and Polyclinic Health System under the name of New Co Health System, as amended by the First Amendment thereto. The Agreement and Plan of Consolidation, as amended, included the representations, warranties and other provisions typically found in such agreements negotiated by independent parties at arm's-length from one another, and its form and content was consistent with such agreements negotiated and consummated between arm's-length parties.

15. Harrisburg Hospital/Seidle Memorial Hospital and Polyclinic Medical Center were not subject to common ownership or common control as defined in Medicare regulations prior to or at the time of the consolidation transaction described in paragraph[10] 12, including when the terms of the transaction were negotiated, when the transaction documents were executed, and when the consolidation became effective. At no such time did any individual who served as a director or officer of any Capital Entity also serve as a director or officer of any Polyclinic Entity.

16. At no time did Pinnacle Health Hospital and Harrisburg Hospital, Seidle Memorial Hospital, or Polyclinic Medical Center simultaneously exist. At no time did Pinnacle Health System and any Capital Entity or Polyclinic Entity simultaneously exist.

17. The members of the governing board of Polyclinic Medical Center, Harrisburg Hospital and Seidle Memorial Hospital at the time of the consolidation and the members of the governing board of Pinnacle Health Hospitals immediately thereafter are set forth on Stipulation Exhibit 1.

18. On behalf of the consolidating entities, by letter dated June 6, 1994, Michael Maher, Coopers & Lybrand, sought agency advice regarding Medicare issues related to the proposed hypothetical consolidation transaction which was substantially similar to the consolidation described in paragraph[11] 12. The agency's response is reflected in a letter to Mr. Maher dated August 24, 1994 from Charles R. Booth, Director, Office of Payment Policy, Bureau of Policy Development, Health Care Financing Administration ("HCFA").

19. Subsequently, on behalf of the consolidating entities, by letter dated August 29, 1995, Mr. Maher sought advice from the consolidating entities' fiscal intermediary. The fiscal intermediary's response was reflected in a letter to Mr. Maher dated September 26, 1995 from Richard C. Rinschler, Director, Provider Audit and Reimbursement. Mr. Rinschler provided a further response to Mr. Maher in a letter dated November 14, 1995.

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[9] Id.
[10] Id.
[11] Id.

20. The loss resulting from the consolidation described in paragraph[12] 12 was computed for Harrisburg Hospital, Seidle Memorial Hospital and Polyclinic Medical Center. The combined loss incurred by Harrisburg Hospital and Seidle Memorial Hospital was reflected on the cost report through which they reported costs as part of a single Medicare provider. Polyclinic Medical Center included the loss that it incurred on the transaction on the cost report through which it reported costs. The loss calculation for each entity was based on an appraisal and related computations performed by Valuation Counselors. In computing each loss, Valuation Counselors offset certain current liabilities against current assets to arrive at a value for net working capital. It then allocated the remaining consideration (liabilities assumed) proportionately among all of the entity's assets (including net working capital) based generally on their values as reflected in the entity's financial records or based on the asset's depreciated reproduction cost as determined by Valuation Counselors. The loss computations are reflected in Stipulation Exhibit 2 (prepared May 2007).

21. By letter dated November 12, 1997, Mr. Rinschler requested advice regarding the loss claims at issue from Mr. Booth. The agency's response was reflected in a letter from Bruce R. Oliver, Director, Division of Cost Reporting, Chronic Care Purchasing Policy Group, Center for Health Plans and Providers, HCFA (date of letter illegible).

22. Based on Mr. Oliver's advice, the Intermediary disallowed the loss claims at issue.

23. Harrisburg Hospital/Seidle Memorial Hospital and Polyclinic Medical Center assert that the loss should be computed by assigning consideration equal to the particular entities' liabilities assumed by Pinnacle Health Hospitals proportionately among all of the assets of the consolidating entity based on their values as reflected in the entity's financial records or based on the asset's depreciated reproduction cost as determined by Valuation Counselors. These computations are reflected in Stipulation Exhibit 3. In the alternative, Harrisburg Hospital/Seidle Memorial Hospital and Polyclinic Medical Center assert that this methodology should be used, however, no consideration should be assigned to medical records and assembled workforce. These alternative computations are reflected in Stipulation Exhibit 4. The Intermediary does not contest the approach used in computing these losses i.e., Stipulation Exhibit 4.

This Stipulation is offered without prejudice to the Intermediary's position that the loss claims at issue have to be analyzed as arising from a transaction between Harrisburg Hospital/Seidle Memorial Hospital, Polyclinic Medical Center and Pinnacle Health Hospital, and the Intermediary's position that the consideration was unreasonable and that the transaction was not a *bona fide* sale.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the consolidation at issue was not a bona fide sale between unrelated parties as required by program rules; therefore, the subject loss is not

[12] Id.

allowable for program reimbursement.[13] The Intermediary cites Program Memorandum (PM) A-00-76 that was issued in October 2000, and clarifies the application of 42 C.F.R. §413.134(l) to mergers and consolidations involving non-profit providers. In pertinent part, the memorandum explains that for a gain or loss to result from a merger or consolidation the asset disposition must result from a bona fide sale. In addition, HCFA Pub. 15-1 §104.24 defines a bona fide sale as a transaction between "unrelated parties," and the PM goes on to explain that a related party determination can be based upon circumstances that exist after a transaction. In part, PM A-00-76 states: [14]

> [t]he fact that the parties are unrelated before the transaction does not bar a related organizations finding as a result of the transaction. That is, it is appropriate to compare the governing board/management team composition before the transaction with the governing board/management team composition after the transaction, even though there was no contemporaneous co-existence of those boards/teams.

With respect to these rules, the Intermediary asserts that the subject consolidation was a related party transaction since 9 out of 22 members of Pinnacle Hospital's Board of Directors, or 41 percent, was comprised of individuals who were on the Provider's board.[15]

Additionally, the subject consolidation was not a bona fide sale because the Provider did not receive "reasonable consideration" for its depreciable assets. Program instructions at section 104.24[16] of Medicare's Provider Reimbursement Manual, Part I (CMS Pub. 15-1) defines a bona fide sale as:

> [a]bona fide sale contemplates an arm's length transaction between a willing and well informed buyer and seller, neither being under coercion, for <u>reasonable consideration</u>. An arm's length transaction is a transaction negotiated by unrelated parties, each acting in its own self interest. (Emphasis added).

The Intermediary notes that Pinnacle Hospitals assumed the Provider's liabilities totaling only $41,428,919 but acquired total assets valued at $106,511,413.[17]

Finally, the Intermediary contends that should the Providers prevail, the loss at issue should be recalculated with no amount of the purchase price being allocated to medical records or assembled workforce. The Intermediary argues that the Medicare program

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[13] Intermediary Position Paper at 5.
[14] Exhibit I-9.
[15] Intermediary Position Paper at 5.
[16] Intermediary Exhibit I-7.
[17] Intermediary Position Paper at 4 and 6.

recognizes an allocation of purchase price to intangible assets only when the purchase price exceeds the fair market value of the tangible assets.[18]

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.[19] The Provider cites 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.

The Provider also contends that the Intermediary's disallowance is not based upon 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.

The Provider asserts that DHHS' Office of Inspector General (OIG) advised intermediaries that hospitals were manipulating the Medicare program to obtain reimbursement for losses that were inappropriate yet in line with all regulatory requirements.[20] The OIG's actions spurred the development of an ad hoc workgroup of HCFA and intermediary representatives 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 should be 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.[21] 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.

[18] Intermediary Position Paper at 6 and 7.
[19] Provider's Post Hearing Brief at 27.
[20] Provider's Final Position Paper at 21.
[21] Provider's Post Hearing Brief at 28. Exhibit P-38, page 52.

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 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.[22]
The Provider also contends that even if "continuity of control" were a valid application of Medicare's related party principles, it does not exist in the instant case.[23] According to 42 C.F.R. §413.17(b), related party principles apply where there is common ownership or control. Control exists where "an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution." With respect to the instant case, no individual controlled even 5 percent of the votes of Pinnacle Hospitals' governing board, and there is no factual basis for an aggregation of voting interests of unrelated individuals who had previously served on the Provider's board.

The Provider contends that the regulatory requirements for a bona fide sale do not apply to consolidations nor do they require "reasonable consideration" as argued by the Intermediary (although, there is no evidence demonstrating that the Provider did not receive reasonable consideration for its depreciable assets).[24]

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 Provider did receive "valuable consideration" for its assets. As a result of the assumption of liabilities by Pinnacle Hospitals, the Provider received over $54 million in consideration including approximately $17.5 million for its fixed assets.[25]

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[22] Provider's Post Hearing Brief at 29. Exhibits P-52 and P-19, respectively.
[23] Provider's Post-Hearing Brief at 38.
[24] Provider's Post Hearing Brief at 41.
[25] Provider's Post Hearing Brief at 48.

Additionally, the Provider explains that its consolidation with Harrisburg/Seidle Hospitals was essential if it was to continue to operate on a profitable basis. The Provider anticipated that managed care's continuing growth would suppress its patient utilization and revenues, and that a 20 percent reduction in its costs would be needed; the Provider had previously been required to lay off employees. [26]

Finally, in order to calculate the subject loss on consolidation, the Provider contends that an allocation of the purchase price to medical records and assembled workforce is consistent with Medicare regulations.[27] An independent appraisal determined that the Provider's medical records and assembled workforce had substantial economic value, and it was appropriate to assign a value to them. Regulation 42 C.F.R. §413.134(f)(2)(iv) states, in part: "[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 assets sold. . . ."

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes that the Provider was unrelated to Harrisburg Hospital/Seidle Memorial Hospital 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 Pennsylvania law and that the regulation at 42 C.F.R. §413.134, "Depreciation: Allowance for depreciation based on asset costs," is applicable.[28] 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."[29] It is undisputed that the Provider and Harrisburg/Seidle Hospitals consolidated, resulting in the creation of Pinnacle Hospitals, with the pre-existing entities ceasing to exist. Under the terms of the transaction, Pinnacle Hospitals (the consolidated

[26] Providers' Post Hearing Brief at 16-17.
[27] Provider's Post Hearing Brief at 54.

[28] 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 A-00-76, states that the regulation applies to nonprofits; however, "special considerations" apply. (Exhibit I-9).
[29] *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.

corporation) 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 Harrisburg/Seidle Hospitals 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, Pinnacle Hospitals, 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, Pinnacle Hospitals. The Intermediary contends that this relationship between the old and new entities 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 memorandum states:[30]

> . . . 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.[31] 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).[32]

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[30] Exhibit I-9, page 2.

[31] The Board acknowledges the Provider's 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 Final Position Paper (Revised) at 21.

[32] Exhibit P-43.

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).[33]

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. Interpretive guidelines published in Medicare's Part A Intermediary Manual (CMS Pub. 13-4 §4502.7) long before the October, 2000 "clarification" state, in relevant part: "Medicare program policy permits a revaluation of assets affected by corporate consolidations between unrelated parties."
Further indication of the Secretary's interpretation of the consolidation regulation can be found in the form of two letters that presented written interpretations from high-level HCFA officials. In a letter dated May 11, 1987,[34] 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 recognition of a gain or loss based on this regulation.[35]

The Board finds that the transaction that resulted in the formation of Pinnacle Hospitals was a bona fide transaction under Pennsylvania corporation law. The completed transaction consolidated three 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

[33] Exhibit P-44.
[34] Exhibit P-52.
[35] Exhibit P-19.

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 in *Cardinal Cushing Hospital/Goddard Memorial Hospital*[36] 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. 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).

Recently, the 10th Circuit Court of Appeals addressed a similar matter in Via Christi v. Leavitt, 509 F.3d 1259 (Via Christi). The court 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 Intermediary's position that, even if a gain or loss is authorized by the regulation, the Providers nevertheless have an additional burden of showing that the transaction constitutes a "bona fide sale." The court decision allowed the Secretary's additional requirement of being a "bona fide sale" based upon the following analysis:

> 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 v. Leavitt, 509 F.3d 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

[36] 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.

term "bona fide transaction"[37] 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 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, Pinnacle Hospitals is nothing more than a combination of the 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 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 Provider was facing a reduction in its revenues that would likely turn to losses in the future unless it could better manage the health care market's overall inpatient capacity to managed care levels through merger, consolidation, or some other type of transaction.[38]

The Board found in *Cardinal Cushing Hospital/Goddard Memorial Hospital*,[39] 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

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[37] Exhibit P-44, 45 Fed. Reg. page 6913.

[38] May 16, 2007 Transcript (Tr.) at 174-176.

[39] 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.

recognized for IRS purposes.[40] 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.[41] 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 its depreciable assets.

The Provider argues that the liabilities assumed by Pinnacle Hospitals for its assets establish the consideration that is to be used as the acquisition cost. The Provider further contends that the acquisition cost resulted from an arm's-length transaction between 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.[42]

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.[43] The Board recognizes that, if this transaction had been structured as a sale with the old provider creating its 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

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

[41] 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 reorganizations. In this matter however, the parties have stipulated (stipulation 12) that the consolidation at issue was not a reorganization under IRS principles or under Pennsylvania statutes.

[42] 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.

[43] 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, many of the services that the two consolidating hospitals were combined, and certain services were removed from one campus to the other. (May 16, 2007 Tr. at 192-193; 269-270).

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 and their successor. Given the 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.[44] 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. The manual incorporates Accounting Principles

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[44] 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. The Board recognizes, however, that under these circumstances, in the “real world,” neither Corporation A nor any other similarly-situated entity may be willing to consolidate with Corporation B.

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."[45] 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.[46] 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 CFR §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,[47] 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:

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

[46] Exhibit P-52.

[47] Exhibit P-18.

> [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 CFR §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.

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.

The Provider asserts that based on the regulatory provision prescribing use of the proportionate value methodology, it properly assigned part of the total consideration received to the value of its medical records and assembled workforce.[48] However, the Board finds that no consideration (liabilities assumed) should be allocated to these items to determine the Provider's loss.

Medical records and assembled workforce are intangible assets that have going concern value and only exist in sales transactions where the sales proceeds exceed the value of the land and other tangible assets involved in the purchase. As noted above, the proceeds at issue in this case did not exceed the value of the tangible assets; therefore, medical records and assembled workforce are not found to exist.

The Board also relies upon Paragraph 39 of Statement No. 141 issued by the Financial Accounting Standards Board (FASB). Relevant to this case, Paragraph 39 explains that intangible assets that do not arise from contractual or other legal rights will be recognized

[48] May 16, 2007 Tr. at 22-24. Note also, at one time the Providers believed a portion of the consideration should be reduced for the costs directly related to the consolidation; however, the Provider ultimately changed its position regarding this matter and concluded that costs directly related to the consolidation should not be used to reduce the consideration at issue.

as assets apart from goodwill only if they are capable of being separated from the acquired entity and sold. The Board does not find that medical records and assembled workforce, even if found to exist, could be separated and sold apart from the Provider's operation. Moreover, Paragraph 39 goes on to state that "an assembled workforce shall not be recognized as an intangible asset apart from goodwill." The Board finds that medical records share the same fundamental characteristics as an assembled workforce.

Even though the Board adheres to its decision that 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." 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. Based upon this bona fide sale transaction definition, we find that there was not bargaining between the buyer and seller. 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. We also find that the consideration received in the consolidation transaction was significantly less than the fair market value of the assets at the time of the transaction.[49]

<u>DECISION AND ORDER</u>:

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 proper calculation of the loss pursuant to the governing regulatory and manual provisions and consistent with the Board's findings concerning allocation to intangibles.

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[49] Intermediary Exhibit I-6, pages 5 and 6.

<u>Board Members Participating</u>:

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Elaine Crews Powell, C.P.A
Yvette C. Hayes
Michael D. Richards, C.P.A.

<u>FOR THE BOARD</u>:

Suzanne Cochran, Esq.
Chairman

<u>DATE</u>: September 26, 2008