CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Sewickley Valley Hospital and The Medical Center, Beaver, PA	Provider Cost Reimbursement Determination for Cost Reporting
Providers	Period Ending: 10/31/96
vs.	
Blue Cross Blue Shield Association/ Vertius Medical Services	Review of:
	PRRB Dec. No. 2007-D19 Dated: February 21, 2007
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in Section 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The Intermediary submitted comments, requesting reversal of the Board's decision with respect to Sewickley Valley Hospital (SVH). The Intermediary also submitted comments requesting that the Administrator affirm the Board's determination with respect to The Medical Center (TMC). Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were also received from the CMS' Center for Medicare Management (CMM) requesting reversal of the Board's decision with respect to SVH and that the Administrator affirm the Board's determination with respect to TMC. The Providers submitted comments, requesting that the Administrator affirm the Board's decision with respect to SVH and reverse the Board's decision with respect to TMC. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's denial of a loss on disposition of assets due to a consolidation of SVH and TMC was proper.[1]

SVH

The Board held that the Intermediary's adjustment with respect to SVH was improper. The Board held that SVH was unrelated to TMC under 42 C.F.R. § 413.17 and § 413.134. Observing that there was no dispute that a consolidation was formed in this case, the Board noted that 42 C.F.R. § 413.134(l) (3) defines a consolidation as "the combination of two or more corporations resulting in the creation of a new corporate entity." In this regard, the Board stated that Valley Medical Facilities (VMF) was formed through "the consolidation of two hospitals into one new entity, with the two pre-existing entities ceasing to exist." VMF acquired all of the constituent hospitals' assets and assumed all of their liabilities.

The Board pointed out that 42 C.F.R. § 413.134(l) (3) states that, if a consolidation is between unrelated parties, as specified in 42 C.F.R § 413.17, the assets of the provider corporation(s) may be revalued. Thus, the Board looked to 42 C.F.R. § 413.17 to determine whether the consolidation was between unrelated parties. The Board acknowledged that CMS Program Memorandum (PM) A-00-76 (Oct. 2000), states that, to determine whether parties are related, the focus of the inquiry is whether significant ownership or control exists between a corporation transferring assets and the corporation receiving them, i.e., the "continuity of control" doctrine rather that whether the constituent corporations were related.

However, the Board concluded from "the plain language of the consolidation regulations" that the related party concept applies only to the entities that are consolidating, and further that the Secretary's intent in drafting the regulations was to look only at the relationship prior to the transaction, and not the relationship after the transaction. The Board also pointed out that the final regulation, adopted in 1979, rejected an earlier proposed version which treated all consolidations as transactions between related parties, and instead, opted for language permitting revaluation of assets where consolidating parties were unrelated. Moreover, the

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[1] Section 4404 of the Balanced Budget Act of 1997 (Pub. Law 105-33) amended §1861(v)(1)(O)(i) of the Social Security Act to terminate Medicare recognition of gains and losses for depreciable assets resulting from either their sale or scrapping. Conforming modifications to the applicable regulation made December 1, 1997 the effective date for implementing the new rule.

Board noted that § 4502.7 of the Intermediary Manual, published prior to CMS Program Memorandum A-00-76, also permitted revaluation of assets for consolidations between unrelated parties. The Board further maintained that two letters from CMS officials supported this position, and that the very nature of the consolidation of corporations results in some overlap of membership on the boards of trustees, as in this case.[2] The Board, therefore, concluded that the related party principle should not be applied to SVH relationship to the new entity, VMF.

The Board also found that the consolidation that resulted in the formation of VMF was a bona fide transaction under Pennsylvania corporation law. The Board emphasized that the consolidation was a result of arms-length bargaining. The concept of two constituent hospitals forming into a new corporation the Board concluded, bars the type of arms-length bargaining between the constituent, SVH, and the new entity, VMF, which the Intermediary contended was necessary. Requiring "bargaining between the constituents and the new entity to be "arms-length" would effectively nullify the regulation's directive to permit revaluation where unrelated parties consolidate.

The Board stated that, as the case under appeal concerns the recognition of losses on the transfer of assets, the Board cannot limit its review only to the related party rules: the transaction at issue must be viewed in light of the specific consolidation regulation at 42 C.F.R § 413.134(l)(3). Thus, the Board found that 42 C.F.R. § 413.134(l)(3) severely limited the application of the related party regulations to consolidations and if applied as the Administrator asserted would emasculate the consolidation regulations.

The Board acknowledged the Administrator's reversal of the Board majority's decision in <u>Cardinal Cushing Hospital/Goddard Memorial Hospital</u> (Cushing),[3] based upon the relatedness of the consolidating corporations to the new entity. However, the Board noted that the Administrator, in that decision, did not explain what converts a consolidation into a mere reorganization of related parties, when consolidations and mergers are to a large extent a form of reorganization. The Board observed, when the regulation was developed, CMS, undoubtedly aware of this actuality, nevertheless distinguished transactions that would result in a depreciation adjustment only by reference to whether the constituent corporations were related. The Board found this fact significant and binding.

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[2] May 11, 1987, letter written by CMS's Director of the Division of Payment and Reporting Policy, Office of Reimbursement Policy. A letter dated August 24, 1998, CMS's Director, Office of Payment Policy, Bureau of Policy Development.

[3] <u>Cardinal Cushing Hospital/Goddard Memorial Hospital</u>, PRRB Dec. No. 2003-D6.

The Board turned to the Providers' claim that they qualify for Medicare reimbursement of the loss, after revaluation. The Board noted that the Providers' argued that the liabilities assumed by the VMF should be treated as consideration determined through arm's-length bargaining among unrelated consolidating parties, and, thus, approximates the fair market value of the transactions. However, the Intermediary contended that the fact that there was no motivation to maximize the sales price indicated that the bargaining was not arms' length. The regulation contemplated an acquisition cost to be determined through arms-length bargaining which would be likely to produce fair market value. The Board acknowledged that there was no "disposition" of assets as that term is used in the regulation on gains and losses. However, the Board found 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. Moreover, the Board added that assumption of debt is a well-recognized component of consideration, and that there usually is no other consideration in a consolidation.

The Board concluded that evidence of a changing healthcare environment and the lacks of a market for provider facilities were persuasive that the SVH incurred a genuine financial loss on the consolidation. The Board also found that such evidence supported the SVH's position that the process of finding a suitable consolidation partner required arms-length bargaining similar to that in a traditional sale, although the Board added that the process may be more imprecise in producing fair market value. Further, the Board noted that the Intermediary Manual supports this view, as reflected in its incorporation of Accounting Principle Bulletin No. 16, (APB No. 16) of generally accepted accounting principles (GAAP), which discusses the revaluation of assets and the gain/loss computation process for various types of business combinations. The Board concluded that APB No. 16 as well as two CMS letters supported the view of treating assumption of liabilities as the fair market value in business combinations, and that a gain or loss is required to be determined under 42 C.F.R. § 413.134(f).

With regard to the calculation of the loss, the Board considered various allocation methodologies, the applicable governing authorities, and the evidence presented, and concluded that the acquisition cost, i.e., the amount of assumed liabilities, should be prorated among SVH's assets transferred using the proportionate value method set forth in 42 C.F.R. § 413.134(f)(2)(iv). According, the Board remanded this matter to the Intermediary for proper calculation of the loss.

TMC

The Board held that the Intermediary's adjustment with respect to TMC was proper. The Board held that TMC was related to VMF under 42 C.F.R § 413.17.

In reaching this determination the Board noted that Valley Health System (VHS) was formed as a result of the corporate reorganization of Consolidated Healthcare Services (CHS), the parent corporation of TMC. The Board further noted that all governance and control of VMF was granted to VHS. Thus, based on these facts the Board determined that the corporate structure of CHS evolved into VHS and that control of VHS never really changed for related party purposes. For practical purposes CHS/VHS was one and the same. While VHS acquired a new subsidiary (VMF) via the consolidation VHS obtained the assets from its old corporation, TMC. In effect, CHS/VHS sold the assets of TMC to itself through the creation of the consolidated corporate provider, VMF. Under 42 C.F.R. § 413.134(l) (3) (ii) if the consolidation is between two or more related corporations as defined in 42 C.F.R. § 413.17, no revaluation of provider assts is permitted. Therefore, the loss claimed by TMC was disallowed in its entirety.

SUMMARY OF COMMENTS

CMM Comments

CMM submitted comments requesting that the Administrator affirm the Board's decision with respect to TMC and reverse the Board's determination with respect to SVH.

CMM stated that the Board incorrectly held "that the plain language of the regulations [42 C.F.R. § 413.17(b)] bars application of the related party principle to a consolidating party's relationship to the new entity." Moreover, the related party doctrine was not as limited as the Board stated. CMM pointed out that CMS has long held that the review for related parties and continuity of control must include the relationship both before and after the transaction. CMM noted that in similar cases that the Board had rejected CMS' argument that a review of the related party and continuity of control doctrine included a review of the relationship both before and after the transaction but that the Administrator had ultimately reversed.[4] CMM further noted that the Administrator's interpretation of the related party and continuity of control doctrine had been recently upheld in the U.S. District Court for the District of Kansas in Via Christi Regional Medical Center, Inc, successor in interest to St. Joseph Medical Center, Inc. v. Leavitt, (Via Christi Regional Medical Center).[5]

[4] Supra. See PRRB Dec. No. 2003-D6.

[5] Via Christi Regional Medical Center, Inc, successor in interest to St. Joseph Medical Center, Inc. v. Leavitt, No. 04-1026-WED, (Sept. 25, 2006) CCH Medicare and Medicaid Guide, New Developments, § 301,911. In Via Christi Regional

Thus, with respect to this particular case, CMM argued that the SVH/TMC consolidation was a related party transaction pursuant to 42 C.F.R. § 413.17 because after the consolidation, each of the constituent hospital corporations maintained a significant presence on the board of directors of the consolidated entity, VHS thereby retaining significant control of its assets. Both still possessed the power at least indirectly to significantly influence the actions or policies of VMF. Thus, the record supports a finding that the Intermediary's disallowance was proper as SVH was a related party because of the continuity of control it maintained after the consolidation.

CMM also commented that the Board erred in finding that 42 C.F.R. § 413.134(l)(3)(ii) allowed the recognition of a loss or gain whereas 42 C.F.R. § 413.134(f) would not. CMM took issue with the Board's statement that the consolidation would not qualify as a bona fide sale under subsection (f), but nevertheless held that subsection (l) compelled the recognition of the loss. CMM stated that subsection (l) specifically makes recognition of loss or gains "subject to" subsection (f) and if a transaction is not in substance a bona fide sale, then that ends the matter and no loss can be allowed. The Board was incorrect when it stated that applying a bona fide sale test to consolidations would necessarily prohibit the recognition of gains or losses after consolidations.

Finally, relying on §104.24 of the Provider Reimbursement Manual (PRM) CMM stated that the transaction was not a bona fide sale because SVH was a related party as demonstrated by the continuity of control it maintained. Therefore, the Intermediary's disallowance with respect to SVH should be upheld by the Administrator.

Intermediary Comments

The Intermediary commented requesting that the Administrator reverse the Board's determination with respect to SVH. The Intermediary argued that the transaction with respect to SVH could not be characterized as a bona fide sale of assets because the large discrepancies between the asset values and the consideration received reflect the lack of an arm's length bargaining, and, thus, the lack of a bona fide sale. Furthermore, the Intermediary contended that SVH, TMC and VHS were related to

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Medical Center, the Court found that it was not arbitrary or capricious or otherwise contrary to law for the Secretary to conclude that the related party rule should be applied to the newly created entity as well as the consolidating corporations because the determination was a clarification of existing regulations required by changed circumstances.

VMF. To support this position that the Administrator should reverse the Board's decision with respect to SVH, the Intermediary cited to St. Joseph Medical Center,[6] and the U.S. District Court for the District of Kansas in Via Christi Regional Medical Center, Successor-in-Interest to St. Joseph Medical Center, Inc., v. Leavitt, No. 04-1026-WED, (Sept. 25, 2006).[7]

With respect to TMC, the Intermediary also commented requesting that the Administrator affirm the Board's favorable finding. However, the Intermediary requested that the denial of the loss be enhanced by a specific finding that TMC did not dispose of their assets in a bona fide sale and that TMC suffered no loss.

Providers' Comments

The Providers commented, requesting that the Administrator affirm the Board's decision with respect to SVH. The Providers stated that it would be arbitrary and capricious for the Administrator to reverse the Board's determination related to the loss claimed by SVH. With respect to TMC the Providers requested that the Administrator reverse the Board's determination. The Providers disagreed with the Board's interpretation that the TMC was somehow related to VHS prior to the consolidation. The Providers stated that at the time of the consolidation, the sole corporate member of TMC was CHS and a finding or relatedness in the above-describe situation ignores substance over form. The Providers content that they could have easily incorporated a new entity to become the parent corporation of VMF, but in order to avoid the cost and expense of incorporating a new entity they chose instead to use an existing corporate entity.

Furthermore, the Providers maintain that there is nothing in the regulations that requires that the parent corporation of the newly formed consolidating entity be unrelated to either of the consolidated entities. The Providers maintain that there are only two requirements that must be present to generate a revaluation of depreciable assets following a consolidation that results in a change of ownership (CHOW): (i) the transaction must be between unrelated parties; and (ii) the transaction must be a valid transaction under the laws of the state in which the providers are located. The Intermediary stipulated that the parties were unrelated at all times prior to the transaction to form VMF. No evidence was produced to show how CHS previously being the sole corporate member of TMC somehow caused CHS to have control over SVH. Thus, the Board's decision affirming the Intermediary's disallowance of the loss claimed by TMC should be reversed.

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[6] See PRRB Dec. No. 2003-D64.

[7] U.S. District Court for the District of Kansas, No. 04-1026-WEB, 2006 U.S. Dist. LEXIS 69053, Sept. 25, 2006.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

I. Medicare Law and Policy -- Reasonable Costs.

Section 1861(v)(1)(A) of the Social Security Act establishes that Medicare pays for the reasonable cost of furnishing covered services to program beneficiaries, subject to certain limitations. This section of the Act also defines reasonable cost as "the cost actually incurred, excluding there from any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The Act further authorizes the Secretary to promulgate regulations establishing the methods to be used and the items to be included in determining such costs. Consistent with the statute, the regulation at 42 C.F.R. § 413.9 states that all payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries.

A. Capital Related Costs.

Reasonable costs include capital-related costs. Consistent with the Secretary's rulemaking authority, the Secretary promulgated 42 C.F.R. § 413.130, which lists capital-related costs that are reimbursable under Medicare. Capital-related costs under Medicare include depreciation, interest, taxes, insurance, and similar expenses (defined further in 42 C.F.R. § 413.130) for plant and fixed equipment, and for movable equipment.

Title VI of the Social Security Amendments of 1983[8] added §1886(d) to the Act and established the prospective payment system (PPS) for reimbursement of inpatient hospital services provided to Medicare beneficiaries. Under this system, hospitals are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge according to a list of diagnosis-related groups. Reimbursement under the prospective payment rate is limited to inpatient operating costs. The Social Security Amendments of 1983[9] amended subsection (a)(4) of §1886 of the Act to add a last sentence which specifies that the term "operating costs of inpatient hospital services" does not include

[8] Pub. Law 98-21.
[9] Section 601(a)(2) of Pub. Law 98-21.

"capital-related costs (as defined by the Secretary for periods before October 1, 1986)... ." That provision was subsequently amended until finally, §4006(b) of OBRA 1987 revised §1886(g)(1) of the Act to require the Secretary to establish a prospective payment system for the capital-related costs of PPS hospitals for cost reporting periods beginning in fiscal year (FY) 1992.

1. Depreciation.

For cost years prior to the implementation of capital PPS, pursuant to the reasonable cost provision of §1861(v)(1)(A) of the Act, the Secretary promulgated regulations on the payment of capital costs, including depreciation Generally, the payment of depreciation is based on the valuation of the depreciable assets used for rendering patient care as specified by the regulation. The Secretary explained, regarding the computation of gains and losses on disposal of assets, that:

> Medicare reimburses providers for the direct and indirect costs necessary to the provision of patient care, including the cost of using assets for inpatient care. Thus, depreciation of those assets has always been an allowable cost under Medicare. The allowance is computed on the depreciable basis and estimated useful life of the assets. When an asset is disposed of, no further depreciation may be taken on it. However, if a gain or loss is realized from the disposition, reimbursement for depreciation must be adjusted so that Medicare pays the actual cost the provider incurred in using the asset for patient care.[10]

Basically, when there is a gain or loss, it means either that too much depreciation was recognized by the Medicare program resulting in a gain to be shared by Medicare, or insufficient depreciation was recognized by the Medicare program resulting in a loss to be shared by the Medicare program. An adjustment is made so that Medicare pays the actual cost the provider incurred in using the asset for patient care.

Although a gain or loss is recognized in the year of the disposal of the asset, the determination of Medicare’s share of that gain or loss is attributable to the cost reporting periods in which the asset was used to render patient care under the Medicare program. Accordingly, although the event of the disposal of the asset may occur after the implementation of capital–PPS, a portion of the loss or gain may be attributable to cost years paid under reasonable costs and prior to the implementation of capital-PPS.

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[10] 44 Fed. Reg. 3980 (Jan 19, 1979).

The regulation at 42 C.F.R. § 413.130 explain, inter alia, that:

> (a) *General rule*. Capital related costs … are limited to:
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> (1) Net depreciation expense as determined under §§ 413.134, 413.144, and 413.149, adjusted by gains and losses realized from the disposal of depreciable assets under 413.134(f).. (Emphasis added.)

The regulation specifies that only certain events will result in the recognition of a gain or loss in the disposal of depreciable assets. The Secretary explained in proposed amendments to the regulation clarifying and expanding existing policy on the recognition of gains and losses, in 1976, that:

> The revision would describe the various types of disposal recognized under the Medicare program, and would provide for the proper computation and treatment of gains and losses in determining reasonable costs.[11]

In adopting the final rule, the Secretary again explained that:

> Existing regulations contain a requirement that any gain or loss realized on the disposal of a depreciable asset must be included in Medicare allowable costs computations… The regulations, however, specify neither the procedures for computation of the gain or loss nor the methods for making adjustment to depreciation. These amendments provide the rules for the treatment of gain or loss depending upon the manner of disposition of the assets. [12] (Emphasis added.)

These rules have been set forth at 42 C.F.R. § 413.134(f), which explains the specific conditions under which the disposal of depreciable assets may result in a gain or loss under the Medicare program. This section of the regulation states:

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[11] 41 Fed. Reg. 35197 (August 20,1976) "Principles of Reimbursement for Provider Costs: Depreciation: Allowance for the Depreciation Based on Asset Costs." (Proposed rule.)

[12] 44 Fed.Reg.3980. (1979), "Principles of Reimbursement for Provider Costs."(Final rule.)

> (1) *General*. Depreciable assets may be disposed of through sale, scrapping, trade-in, exchange, demolition, abandonment, condemnation, fire, theft, or other casualty. If disposal of a depreciable asset results in a gain or loss, an adjustment is necessary in the provider's allowable cost. The amount of a gain included in the determination of allowable cost is limited to the amount of depreciation previously included in Medicare allowable costs. The amount of a loss to be included is limited to the undepreciated basis of the asset permitted under the program. The treatment of the gain or loss depends upon the manner of disposition of the asset, as specified in paragraphs (f)(2) through (6) of this section ….(Emphasis added.)

The method of disposal of assets set forth at paragraph (f)(2) through (6) is as follows. Paragraph (f)(2) addresses gain and losses realized from the bona fide sale of depreciable assets and states:

> *Bona fide sale or scrapping*. (i) Except as specified in paragraph (f)(3) of this section, gains and losses realized from the bona fide sale or scrapping of depreciable assets are included in the determination of allowable cost only if the sale or scrapping occurs while the provider is participating in Medicare…. (Emphasis added).

With respect to paragraph (f) (2) and the bona fide sale of a depreciable asset, § 104.24 of the PRM states that:

> A bona fide sale contemplates an arm's length transaction between a willing and well informed buyer and seller, neither being under coercion, for reasonable consideration. An arm's length transaction is … negotiated by unrelated parties, each acting in its own self interest.[13]

Paragraph (f)(3) addresses gains or losses realized from sales within 1 year after the provider terminates from the program, while 42 C.F.R. § 413.134(f)(4) addresses exchange trade-in or donation[14] of the asset stating that: "[g]ains or losses realized

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[13] Trans. No. 415 (May 2000) (clarification of existing policy).

[14] A donation is defined in 42 C.F.R. § 413.134((b)(8). An asset is considered donated when the provider acquires the assets without making payment in the form of cash, new debt, assumed debt, property or services. Section 4502.12 of the Intermediary Manual states that when a provider is donated as an ongoing facility to

from the exchange, trade-in, or donation of depreciable assets are not included in the determination of allowable cost." Finally, paragraph (f)(5) explains that the treatment of gains and losses when there has been an abandonment (permanent retirement) of the asset, and paragraph (f)(6) explains the treatment when there has been an involuntary conversion, such as condemnation, fire, theft or other casualty.

2. Revaluation of Assets.

Historically, as reflected in the regulation, the disposal of a depreciable asset used to render patient care may result in two separate and distinct reimbursement events: 1) the calculation of a gain or loss for the prior owner and 2) a revaluation of the depreciable basis for the new owner. While the determination of gains and losses is generally only of interest to the prior owner,[15] the new owner in the same transaction is interested in the determination of when Medicare will allow the revaluation of depreciation for purposes of calculating the new owner's depreciation expense.

This latter issue, on the revaluation of assets, was the subject of significant litigation for the Medicare program regarding complex transaction and resulted in agency rulemaking on the subject. In response to litigation, the regulations at 42 C.F.R. §413.134()[16] were promulgated to address longstanding Medicare policy regarding depreciable assets exchanged for capital stock, statutory mergers and consolidation. Concerning the valuation of assets, the regulation states that:

> (l) *Transactions involving a provider's capital stock*—
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> ****
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> (3) *Consolidation*. <u>A consolidation is the combination of two or more corporations resulting in the creation of a new corporate entity.</u> 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:

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an unrelated party, there is no gain/loss allowed to the donor. The valuation of the assets to the donor depends upon use of the assets prior to the donation.

[15] While this is the general rule, the new owner can also have an interest in the gain or loss, when the new owner is to acquire the Medicare receivables for the terminating cost report along with the depreciable assets.

[16] Originally codified at 42 C.F.R. § 405.415(l).

> (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.
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> (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. (Emphasis added.) [17]

However, paragraph (l) is silent with respect to the determination of a gain or loss for corporations that consolidate.

B. Related Organizations

Finally, 42 C.F.R. § 413.134 references the related organization rules at 42 C.F.R. § 413.17. The regulations at 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.
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> (2) *Common ownership*. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.
>
> (3) *Control*. Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

Consistent with the Act and the regulations, the above principles are set forth in the PRM, which provides guidelines and policies to implement Medicare regulations for determining the reasonable cost of provider services. In determining whether the parties to a transaction are related, the PRM at § 1004 et. seq., establishes that the tests of common ownership and control are to be applied separately, based on the facts and circumstances in each case. With respect to common ownership, the PRM at § 1004.1 states:

> This rule applies whether the provider organization or supplying organization is a sole proprietorship, partnership, corporation, trust or

[17] See also 44 Fed. Reg. 6912-14 (Feb. 5, 1979).

> estate, or any other form of business organization, proprietary or nonprofit. In the case of nonprofit organization, ownership or equity interest will be determined by reference to the interest in the assets of the organization (e.g., a reversionary interest provided for in the articles of incorporation of a nonprofit corporation).[18]

Concerning the definition of control, the PRM at § 1004.3 states: "[t]he term 'control' includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised." The concept of "continuity of control" is illustrated at § 1011.4 of the PRM, in Example 2 which reads as follow:

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

The related party organization was further explained in HCFA Ruling 80-4 which adopted the Eighth Circuit Court of Appeals' decision in Medical Center of Independence v. Harris, (CCH) Para. 30,656 (8th Cir. 1980) The Ruling pointed out that the applicability of the related organization rule is not necessarily determined by the absence of a relationship between the parties prior to their initial contracting, although those factors are to be considered. The applicability of the rule is determined by also considering the relationship between the parties according to the rights created by their contract. The terms of the contracts and events which occurred subsequent to the execution of the contract in that case had the effect of placing the provider under the control of the supplier.

C. Non-Profit Corporations and the Related Parties and Disposal of Depreciable Asset Regulations.

1. Program Memorandum A-00-76.

To clarify the application of 42 CFR §413.134(l) to non-profit providers with respect to the related party rules and the rules on the disposal of depreciable assets, CMS issued Program Memorandum (PM) A-00-76, dated October 19, 2000. This PM applies the foregoing regulations to the situation of non-profit corporations. In

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[18] Trans. No. 272 (Dec. 1982)(clarifying certain ambiguous language relating to the determination of ownership or equity interest in nonprofit organizations.)

particular, this PM noted that non-profits differ in significant ways from for–profit organizations. Non-profit organizations typically do not have equity interests (i.e. shareholders, partners), exist for reasons other then to provide goods and services for a profit, and may obtain significant resources from donors who do not expect to receive monetary repayment of or return on the resources they provide. These differences, among others, cause non-profit organizations to associate or affiliate through mergers or consolidations for reasons that may differ from the traditional for-profit merger or consolidations. In contrast, the regulations at 42 C.F.R. § 413.134(l) were written to address only for-profit mergers and consolidations.

The PM also noted that, unlike for-profit mergers or consolidations, which often involve a dispatching of the former governing body and/or management team, many non-profit mergers and consolidations involve the continuation, in whole or part, of the former governing board and/or management team. Thus, in applying the related organization principles of 42 C.F.R. § 413.17, CMS stated that consideration must be given to whether the composition of the new board of directors, or other governing body and/or management team include significant representation from the previous board or management team. If that is the case, no real change of control of the assets has occurred and no gain and loss may be recognized as a result of the transaction. This PM A-00-76 recognized that, inter alia, certain relationships formed as a result of the consolidation of two entities constituted a related party transaction for which a loss on the disposal of assets could not be recognized. The PM A-00-76 stressed that "between two or more corporations that are unrelated" should include the relationship between the constituent hospitals and the consolidating entity. Consequently, the PM A-00-76 states that:

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

PM A-00-76 stated that the term significant, as used in PM A-00-76 has the same meaning as the term significant or significantly, in the regulations at 42 C.F.R. 413.17 and the PRM at Chapter 10. Important considerations in this regard include that the determination of common control is subjective; each situation stands on its own merits and unique facts; a finding of common control does not require 50 percent or more representation; there is no need to look behind the numbers to see if control is actually being exercised, rather the mere potential to control is sufficient.

In addition, PM A-00-76 stated that many non-profit mergers and consolidations have only the interests of the community at large to drive the transaction. This

community interest does not always involve engaging in a bona fide sale or seeking fair market value of assets given. Rather, the assets and liabilities are simply combined on the merger/consolidated entities books. The merged/consolidated entity may or may not record a gain or loss resulting from such a transaction for financial reporting purposes. However, notwithstanding the treatment of the transaction for financial accounting purposes, no gain or loss may be recognized for Medicare payment purposes unless the transfer of the assets resulted from a bona fide sale as required by the regulation at 42 C.F.R. § 413.134(l) and as defined in the PRM at section 104.24. The PM stated that the regulation at 42 C.F.R. § 413.134(l) does not permit a gain or loss resulting from the combining of multiple entities' assets and liabilities without regard to whether a bona fide sale occurred. The PM stressed that a bona fide sale requires an arm's length business transaction between a willing and well-informed buyer and seller. This also requires the analysis of the comparison of the sales price with the fair market value of the assets acquired as reasonable consideration is a required element of a bona fide sale.

Notably, the Administrator finds that the requirement that the term "between related organizations" include an examination of the relationship before and after a transaction of assets under 42 CFR §413.417[19] was applied as early as 1977 by the agency in evaluating whether accelerated depreciation would be recaptured. The agency decided that "when the termination of the provider agreement results from a transaction between related organizations and the successor provider remains in the health insurance program and its asset bases are the same as those of the terminated providers, health insurances reimbursement is equitable to all parties": thus, the depreciation recovery provisions would not be applied.[20] The agency looked specifically at whether, in a related party transaction, the control and extent of the financial interest remained the same for the owners of the provider <u>before and after</u> the termination.[21] Thus, PM A-00-76 interpretation of the related party rules as requiring an examination of the relationship before and after the transfer of assets is consistent with early Medicare policy and HCFAR 80-4.

This interpretation, that "between related organizations" must include an examination of all parties to the transaction, both before and after, is also consistent with the reality of a transaction involving the consolidation of entities: the deal is initially between the consolidating entities, but, as part of the consolidation, they will cease to exist effective with the consolidation. In contrast, the transfer of the

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[19] Originally codified at 42 C.F.R. § 405.427

[20] 42 Fed. Reg. 45897 (1977).

[21] 42 Fed. Reg. 45897, 45898 (September 15, 1977) (Recovery of excess cost resulting from the use of accelerated depreciation when termination of provider agreement results from transaction between related organizations.)

assets is between the consolidating entities and the newly created corporation. Thus, the parties to the transaction involve the consolidation corporations and the newly created corporation. Hence, Medicare reasonably examines the relationship between the consolidating corporations (transferor) and the newly created corporation and recipient of the Medicare depreciable assets (transferee) to determine whether the transfer involved a related party transaction.

Finally, this interpretation set forth in the PM is not inconsistent with the language of 42 CFR 413.134(l)(3)(ii) that refers to "between two or more corporations that are related" with respect to proprietary corporations. CMS has always recognized a consolidation as a transaction wherein two or more corporations combine to create a new corporation. That is, CMS has always recognized that the parties to a consolidation are the consolidating corporations and the newly created corporation. Therefore, CMS reasonably applies the related parties' rules in requiring an examination of the relationships of the consolidating corporations and the newly created corporation.

2. The Intermediary CHOW Manual and APB No. 16.

The Intermediary Manual, Chapter 4000, et seq., also addresses changes of ownership (CHOW) for purposes of Medicare certification and reimbursement. These sections provide guidelines based on Medicare law, regulations and implementing instructions for use by the Medicare intermediaries and providers on the reimbursement implications of various types of changes of provider organizations transactions or CHOWs. Section 4502 explains that the first review of a CHOW transaction is to determine the type of transaction which occurred as the Medicare program has developed specific policies on the reimbursement effect of various types of CHOW transactions which may be different from treatment under generally accepted accounting principles or GAAP.

Corporations are included as one of the possible types of provider organizations. Section 4502.1 explains that a corporation is a legal entity which enjoys the rights, privileges and responsibilities of an individual under the law. An interest in a corporation is represented by shares of stock in proprietary situations (stockholders) or membership certificates in non-stock entities (members).

Among the various types of provider structures and transactions recognized by Medicare are mergers, consolidations, and corporate reorganizations at § 4502. Section 4502. 7 describes a consolidation as similar to a statutory merger, except that a new corporation is created. Medicare program policy permits a revaluation of assets affected by a corporate consolidation between unrelated parties. Notably, Medicare policy at § 4502.10 does not permit a revaluation of assets affected by a

"reorganization" of a corporate structure. All such transactions are considered among or between related parties. As an example the Intermediary Manual explains that:

> Provider A is organized as a nonprofit corporation. The assets of provider A are reorganized under state law into a newly created proprietary corporation. The transaction constitutes a related party transaction (i.e., corporate reorganization). As the transaction was among related organizations no gain/loss is allowed for the seller and no revaluation is allowed for the buyer.

In the instance of reorganization, CMS examines, inter alia, the parties before and after the transaction in determining that the transfer of assets involved a related party transaction.

Section 4508.11 of the Intermediary Manual,[22] in addressing stock corporations. Medicare program policy places reliance on the generally accepted accounting principles or GAAP, as expressed in Accounting Principles Bulletin (APB) No. 16 in the reevaluation of assets and gain/loss computation processes for Medicare reimbursement purposes. While in certain areas, Medicare program policy deviates from that set forth in GAAP,[23] Intermediaries are instructed to refer to the principles outlined in the CHOW manual which specify when reference to APB No. 16 is in accordance with the current Medicare policy.[24]

Generally, APB No. 16 suggests two approaches to the treatment of assets when there is a business combination involving stock corporations: the pooling method and the purchase method. Historically, a combination of business interest was characterized as either a "continuation of the former ownership" or "new ownership." A continuation of ownership was accounted for as a pooling of interest. The pooling of interest method accounts for business combinations as the uniting of the ownership interests of two or more companies. No acquisition is recognized because the combination is accomplished without disbursing resources of

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[22] Section 4504.1 states that: "where Medicare instructions are silent as to the valuation of consideration given in an acquisition, rely upon generally accepted accounting principles. APB No. 16 discusses valuation methods of consideration given for assets acquired in business combinations."

[23] For example, Medicare will not recognize a revaluation/gain or loss due to a transfer of stock or in the case of a "two-step" transaction (i.e., the transfer of stock, than the transfer of the depreciable assets).

[24] FASB superseded APB No. 16 effective June 2001. However, at the present, not-for-profit (NFP) organizations are excluded from the scope of FASB No. 141.

the constituents and ownership interests continue. The pooling of interests method results in no revaluation of assets or recording of gains or losses. In contrast, "new ownership" is accounted for as a purchase. The purchase method accounts for a business combination as the acquisition of one company by another and is treated as purchase or sale. Thus, APB No. 16 is similar to the PM, in that both recognize and treat the pooling of interests in a business combination as an event resulting in no gain or loss, while recognizing and treating a bona fide purchase or sale in a business combination as an event resulting in a gain or loss.

D. Similarities of Internal Revenue Service Principles and Medicare Reimbursement Principles When Entities Consolidate.

This policy of not recognizing a gain or loss when the transaction is between related parties, whether it constitutes a reorganization or consolidation, is also consistent with Internal Revenue Service (IRS) rules on the non-recognition of a gain or loss when a statutory reorganization has been determined to have occurred. Relevant to this case, while the Medicare rules may diverge from IRS rules and Medicare policy is not bound by IRS policy, IRS policy often reflects rationale underlying the establishment of similar policies under Medicare.[25] In fact, in setting forth principles applicable to the recognition of the gain or a loss, CMS has in the past recognized the similarity of the Medicare principles and the IRS principles and has often explicitly stated when such Medicare policy agrees or diverges from IRS treatment.[26]

Under IRS rules, some consolidations are considered statutory reorganizations and subject to the non-recognition of a gain or loss. The terms reorganization and consolidation are not mutually exclusive terms under IRS rules. Medicare policy similarly indicates that they are not mutually exclusive terms under Medicare rules. That is, consolidations and mergers may in fact constitute in essence,

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[25] See, e. g., Guernsey v. Shalala, 115 S. Ct. 1232 (1995), analogizing Medicare rules to IRS rules in citing to Thor Power Tools v. Commissioner, 439 U.S. 522 (1979).

[26] See, e.g., 44 Fed. Reg. 3980 (January 19, 1979) ("If a provider trades in or exchanges an asset, no gain or loss is included in the computation of allowable cost. Instead, consistent with the Internal Revenue Service (IRS), the undepreciated value of the traded asset, plus any additional assets transferred to acquire the new assets, are used as the basis for depreciation of the new asset under Medicare"; 48 Fed. Reg. 37408 (Aug. 18. 1983) (finding that it was not appropriate for the Medicare program to use IRS accelerated costs recovery system for Medicare purposes and deleting IRS useful life guidelines).

reorganizations and reorganizations may involve more than one corporation.[27] For example, a consolidation where the predecessor corporation board continues significant control in the new corporation board is treated the same as a reorganization for Medicare reimbursement purposes and no gain or loss is recognized. However, for example, where the predecessor corporation board does not continue significant control in the new corporation board, a gain or loss will be recognized for Medicare reimbursement purposes.

Similar to Medicare rules, the IRS does not allow the recognition of the gain or loss when there is a reorganization, inter alia, because no gain or loss has in fact been realized. As the courts have noted:

> The principle under which statutory reorganizations are not considered taxable events is that no substantial change has been affected either in the nature or the substance of the taxpayer's capital position, and no capital gain or loss has actually been realized. Such a reorganization contemplates a continuity of business enterprise and a continuity of interest and control accomplished [in this instance] by an exchange of stock for stock.[28] (Emphasis added.)

Similarly, the courts have stated that the underlying purpose of the IRS provisions that find no gain or loss when there is a reorganization was twofold: "1) to relieve certain types of corporate reorganizations from taxation which seemed oppressively premature and 2) to prevent taxpayer's from taking losses on account of wash sales and other fictitious exchanges."[29] Finally, as the Supreme Court found in Groman v. Commissioners, 302 U.S 82, 87 (1937) certain transactions speak for themselves, regardless of how they might be cast. As the Supreme Court observed: "If corporate

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[27] See also Black's Law Dictionary definition of a reorganization used interchangeably with merger and consolidation("A reorganization that involves a merger or consolidation under a specific State statute.")

[28] Commissioners of IRS v. Webster Estates, 131 F. 2d 426, 429 (2nd Cir.1942) citing Helvering v. Schoellkopf, 100 F. 2d 415 (2d Cir) While the foregoing IRS cases illustrate the continuity of interest, the Administrator notes that the Medicare program does not recognize a loss on sale as a result of a stock transfer regardless of the relationship between the parties. Case law also shows that term "continuity of interest" as provided in the IRS regulation is at times used interchangeably with the term "continuity of control." See e.g. New Jersey Mortgage and Title Co. v. Commissioner of the IRS, 3 T. C. 1277 (1944); Detroit–Michigan Stove Company v. U.S., 128 Ct. Cl. 585 (1954).

[29] C.H. Mead Coal Co. v. Commissioners of IRS, 72 F. 2d 22, 27-28 (4th Cir. 1934) (analyzing early sections of the code.)

A and B transfer assets to C, a new corporation, in exchange for all of C's stock, the stock received is not a basis for calculation of a gain on the exchange… A and B are so evidently parties to the reorganization that we do not need [the IRS code] to inform us of the fact." In sum, the purpose of these provisions is "to free from the imposition of an income tax purely 'paper profits or losses' wherein there is no realization of gain or loss in the business sense but merely the recasting of the same interests in a different form."[30]

The IRS rules also deny gains or losses from the sale or exchange of property between related parties. In explaining the rationale for this tax law provision, the court in Unionbancal Corporation v. Commissioner, 305 F. 2d 976 (2001), explained that:

> This limitation on deductions for transfers between related parties, protects the fisc against sham transactions and manipulations without economic substance. Not infrequently though, there are honest and important non-tax reasons for sales between related parties, so it's important to fairness to preserve the pre-sale basis where loss on the sale itself isn't recognized for tax purposes. Otherwise the statute would be a heads-I-win, tails-you-lose provision for the IRS: the seller can't take the loss, but the IRS calculates the buyer's gain on resale using the lower basis.

Consequently, one purpose of the IRS policy is to prevent the claiming of a gain or loss when no such event has in fact occurred. Similarly, the related party rules under Medicare, in holding that there is no recognition of a gain or loss when there is a reorganization, or consolidation between related parties, is to avoid the payment of costs not actually incurred by the parties. An overarching principle applicable under the Medicare statute and regulation, with which all reasonable cost regulations must be in accord, is the principle that Medicare will only share in costs actually incurred by the provider. Consistent with IRS rules which recognize that no cost has been incurred under the foregoing facts, Medicare similarly does not find that the provider has incurred an actual cost for purposes of Medicare reimbursement under such facts.

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[30] Paulsen ET UX v. Commissioner, 469 U.S. 131 (1985) citing Southwest Natural Gas Co. v. Commissioner, 189 F. 2d 332, 334 (CA 5), cert. denied, 342 U.S. 860 (1951) (quoting Commissioner v. Gilmore's Estate, 130 F. 2d 791, 794 (CA 3 1942)).

II. Finding of Facts and Conclusion of Law.

A. Denial of loss due to consolidation between related parties.

On April 30, 1996, CHS, TMC and SVH executed and "AGREEMENT OF CONSOLIDATION" (Agreement), which was amended on October 29, 1996.[31] The effective date of the consolidation was November 1, 1996.[32] Prior to the consolidation date, SVH was a licensed 209 bed nonprofit general acute care hospital located in Pittsburgh, Pennsylvania.[33] In addition, prior to the consolidation date, TMC was a licensed 468 bed nonprofit general acute care hospital located in Beaver, Pennsylvania.[34] CHS was the sole corporate member of TMC[35] At all times prior to the consolidation date, SVH and CHS/TMC were not related. SVH and CHS/TMC did not have common ownership, common officers or common board members.

Pursuant to the Agreement, a new corporation, Valley Medical Facilities, Inc. (VMF) was to be formed.[36] Pursuant to Pennsylvania law, SVH and TMC would no longer exist as a result of the consolidation.[37] VMF, the new corporation, assumed all the rights, powers, authorities, responsibilities and liabilities of TMC and SVH. All assets and property of TMC and SVH transferred to VMF by operation of Pennsylvania law. The ultimate governance and control of VMF was granted to Valley Health System (VHS), the sole corporate member of VMF. VHS was formed as a result of a corporate reorganization of CHS.[38] The initial board of VHS was composed of twenty (20) directors. Six of these directors had formerly been

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[31] See Intermediary's Exhibit I-5, Providers' Exhibit P-2. The copy of the Agreement in the record did not include the Exhibits of, inter alia, the Articles of Incorporation of VMF/VHS and Officers of VMF/VHS.
[32] TMC Provider's Position Paper 5-6.
[33] See SVH Provider's Position Paper at 2.
[34] See TMC Provider's Position Paper at 2.
[35] Id.
[36] See Intermediary's Exhibit I-5 at 2.
[37] See 15 Pa. C.S.A. § 5929.
[38] See Provider's Position Paper a 6. Effective November 1, 1996, CHS's articles, bylaws, and board were restructured to form VHS. In addition, CHS' named was changed to Valley Health System. As the sole corporate member of VMF, VHS retained certain reserve powers over VMF including appointment of the VMF board of directors.

members of the SVH board. Six had formerly been members of TMC board. Six were not members of the SVH, CHS or TMC boards but were chosen as representatives of the local community and two *ex officio* members of the VHS board had been CHS directors.

SVH and TMC timely submitted their final cost reports for fiscal year end (FYE) October 31, 1996 in which they requested that they be allowed to recognize as allowable cost the losses they claimed they each incurred on the disposal of their assets to VMF in connection with the consolidation. Specifically, SVH claimed a loss of $12,489,000 and TMC claimed a loss of $13,825,000.

By letters dated December 30, 1998 and January 18, 1999, the Intermediary issued NPRs to both TMC and SVH respectively, denying the Providers' claim related to a loss on sale of assets for the cost reporting period ending 10/31/96.[39] By letters dated June 15, 1999, the Providers' appealed.

Applying the foregoing provisions to the facts of this case, the Administrator finds that SVH and TMC, the constituent entities, are not entitled to a loss on the disposal of their assets because the constituent entities were related to the consolidated entity VMF/VHS pursuant to 42 C.F.R. § 413.17. For a gain or loss to be realized on the disposal of assets, the Administrator finds that the consolidation in this case, must have occurred between parties that are not related. The Administrator further finds that in determining whether the parties to a transaction are related that the test of common ownership and control are to be applied separately, based on the facts and circumstances in each case.[40]

In this case, the record shows, prior to the consolidation date to form VMF, that SVH was not related to CHS or TMC. The record shows that after the consolidation the newly formed consolidated entity, VMF assumed all the rights, powers, authorities, responsibilities and liabilities of SVH and TMC. Furthermore, the record shows that the ultimate governance and control of VMF was granted to VHS as the sole corporate member. The record shows that VHS was formed as a result of a corporate reorganization of CHS and that after the consolidation VHS governing board consisted of 20 directors, six (6) of which had been members of SVH board of directors; six (6) who had been member of the TMC board of directors, six (6) newly appointed board members from the community who had not been members of either SVH, CHS or TMS board and two (2) *ex officio* members of CHS board of directors.

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[39] Intermediary's Exhibit I-4.

[40] 42 C.F.R. § 413.17(b); PRM § 1004 et. seq.

In addition, with respect to SVH, unrebutted was the Intermediary's finding that Donald Spalding was the President and Joseph Calhoun, the CEO for SVH before the consolidation and the same for VMF/VHS after the consolidation.[41] Likewise, with respect to TMC, Larry Crowell was President and CFO and Norman Mity was Vice-President of TMC before the consolidation and the same for VMF/VHS after the consolidation.[42]

Thus, because a significant number of board members and officers from SVH and TMC moved over to the VHS board of directors and executive officer positions, the Administrator finds that SVH and TMC retained "significant" control of its assets showing a continuity of control in the consolidated entity VMF/VHS. The Administrator finds that SVH and TMC both continued to possess the power at least indirectly to significantly influence the actions or policies of VMF/VHS. Accordingly, the Administrator finds that the Intermediary in this case correctly determined that SVH and TMC, the constituent entities, were related to the VMF/VHS and that a loss on the disposal of assets cannot be recognized under Medicare because of the continuity of control it maintained after the consolidation. Therefore, the Board's determination is modified and its findings with respect to SVH is reversed and its finding with respect to TMC is affirmed.

The Administrator notes that the Board also made several findings regarding the interaction of the various regulations on 42 C.F.R. § 413.134(l).[43] The Board found that the final rule at 44 Fed. Reg. 6913 (1979) conclusively limits the application of

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[41] SVH Intermediary Position Paper, Exhibit I-6

[42] TMC Intermediary Position Paper, Exhibit I-6

[43] While not dispositive to this case, the Board concluded that the CMS policy on consolidation revaluations in the final rule published Feb 5, 1979 was a change from the proposed rule published in April 1, 1977. However, the final rule would appear to contradict that conclusion also made by the Providers' witness, the former CMS official. The final rule states that it does not differ in substance from the proposed rule (44 Fed Reg. 6913) and it was made effective on the date published, an act consistent with that statement. An immediate effective date for any substantive change would have required a good cause exception under the APA published in the final rule. The final rule also stresses that the policy that the rule clarifies on the revaluation of assets is longstanding policy Medicare policy and does not note any changes on consolidations as a result of comments. The change referenced from the proposed rule is that the final rule dedicates separate paragraphs to related and unrelated transactions involving consolidations, similar to that provided for statutory mergers. Thus, based on the foregoing, one could conclude that this change was to clarify the proposed language, rather than to promulgate a substantive change from the proposed rule.

the related party rule to the consolidating entities. Further, the Board found that the general rules on the disposal of assets and related parties were not controlling over the specific language of paragraph (l). While the general related party rules could be interpreted to require an examination of the relationship between the consolidating corporations and the new corporation, the Board found that interpretation could not be applied to the transactions involving consolidation under paragraph (l). Moreover, the Board found that the specific provisions of paragraph (l) precluded the application of the bona fide sale requirement of the disposal of assets provisions of paragraph (f). The Board found that there was no requirement that depreciable assets be disposed of through a bona fide sale and that such a requirement was contrary to the nature of consolidations.

However, the Administrator finds that, as the issue under appeal involves the recognition of depreciation losses on the transfers of assets from a consolidation between non-profit entities, the Administrator cannot limit the review to 42 C.F.R. § 412.134(l). Paragraph (l) was drafted specifically to address the revaluation of assets for proprietary corporations that consolidate, while paragraph (f) specifically addresses circumstances under which a gain or loss will be recognized. Paragraph (l) did not modify or limit the general related party rules at 42 C.F.R. § 413.17 and does not address or modify the criteria for the recognition of gains or losses at paragraph 42 C.F.R. § 413.134(f). Instead, the Secretary explicitly stated that this provision was being promulgated consistent with both the related party rules and the disposal of depreciable asset rules set forth at paragraph (f) and thus must be interpreted consistent with those provisions.[44]

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[44] See, e.g., 44 Fed. Reg. 6912 (Feb 5, 1979)("Although no single provision of the Medicare regulations explicitly set forth these policies, our position has been based on the interaction of three regulations: 42 CFR 405.415, concerning the allowance for depreciation based on asset costs; 42 CFR 405.427, concerning cost related organizations; and 42 CFR 405.626, concerning change of ownership. We continue to believe that our interpretation and application of these regulations are reasonable and consistent with our statutory mandate to determine the scope of the reasonable costs for Medicare providers." (Emphasis added.)); 42 Fed. Reg. 6912 ("Our intent is not to change existing Medicare policy, but merely to state explicitly in the Code of Federal Regulations that which has been stated in the past in less formal settings."); 42 Fed. Reg. 17486(1977)("The proposed revision of paragraph (l) of 405.415 is also consistent with paragraph (f). When a provider's assets are sold the transaction causes adjustments to the seller's health insurance program allowance for the depreciation based upon the gain or loss on the sale of the asset. Because a sale of corporate stock is not a sale of the corporate assets, the provisions of paragraph (f) of 405.415 are not applicable to the seller after such a transaction.");

In addition, contrary to the Board's finding, the CMS policy of examining the relationship between the corporations that transfers the assets and the corporation that receives the assets, does not obviate the application of the gain and loss provisions in all transactions involving a consolidation. For example, the PM A-00-76 illustrates circumstances when there is a consolidation that results in the calculation of a gain or loss. The PM A-00-76 Example 2 explains that:

> Corporation A and B consolidate to form Corporation C. Corporation A and B were unrelated prior to the transaction, each being controlled by its respective Board of Directors of eight members each. After the consolidation, Corporation C's Board of Directors consists of seven individuals, all of whom were members of Corporation A's board. Because no significant change of control of assets of corporation A occurred, the transaction as between A and C is deemed to be one of related parties and no gain and loss on it will be recognized as a result of the transaction. However, because there has been a significant change of control of the assets of Corporation B, the transaction as between B and C is not one of the related parties. Therefore, with respect to the assets transferred from B to C, a gain or loss may be recognized (if the other criteria for recognizing a gain or loss, including the requirement of a bona fide sale are met.)

As set forth in the foregoing example, a rule that looks at the parties before and after the transaction does not make superfluous the gain or loss provisions whenever there is consolidation or merger. For example, only in circumstances where there is a continuity of control between the former owner of the assets and the new owner of the assets is the transfer recognized as between related parties and no gain or loss allowed. "The fact that parties are unrelated before the transaction does not bar a related organization finding," and in fact "whether the constituent corporation in a merger or consolidation are or are not related is irrelevant; rather the focus of the inquire should be whether significant ownership or control exist between corporation that transfers assets and the corporation that receives them." In fact, the Board itself appears to have looked at the relationship of the parent corporation of the constituent entity TMC and the parent corporation of consolidated entity VMF/VHS in finding relatedness.

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44 Fed. Reg. 6913 ("Only if the assets are transferred by means of a bona fide transaction between unrelated parties would revaluation be proper.")

In addition, especially in light of the evolving healthcare industry and financing practices of non-profit providers, the Secretary is not prohibited from looking beyond the technical form of the parties or entities involved and assessing the practical effects of the transaction. When a provider alleges to have suffered a loss from the transfer of its assets to another entity, it makes sense to compare the ownership or control of the transferors and the transferee entities in determining whether the same person or parities who owned or controlled the transferor entity actually realized a loss. If the consolidation was merely a pooling of resources then a loss could not be assessed because the combination was accomplished without disbursing resources of the constituents and therefore was a continuation of the former ownership interest. The clarification set forth in the PM recognizes these changes in the healthcare environment for non-profits that results in such entities pooling their resources in response to such changes.

Furthermore, the Administrator finds that the rationale for finding that this entire transaction constitutes a related party transaction under Medicare policy is compelling. An overarching principle of Medicare reimbursement, which serves as the basis for the prophylactic related party rule, is that only costs actually incurred are reimbursable under Medicare. Thus, it is reasonable to find in this case that SVH's and TMC's interests have been but recast in a different form only and, thus, a loss has not actually been incurred by SVH or TMC that can be recognized by Medicare under § 1861(v)(1)(A) of the Act.[45]

B. Denial of Reimbursement due to lack of bona fide sale.

The Administrator also finds that the disposals of asset rules of paragraph (f) are properly applied in the event of a consolidation. This means that in order for a loss to be recognized, a transaction resulting in the transfer of depreciable assets must meet one of the applicable criteria of paragraph (f) such as a bona fide sale. Applying the rules to the facts of this case, the Administrator finds that SVH's and TMC's transfer of the assets to VMF/VHS did not constitute a bona fide sale. Section § 104.24 of the PRM states:

> A bona fide sale contemplates and arms 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…negotiated by <u>unrelated parties</u>, each acting in its own set interest. (Emphasis added.)

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[45] Therefore, regardless of whether this transaction qualifies as reorganization under present Federal or State tax rules and is treated as a non recognizable loss, it cannot be allowed under Medicare rules as a loss on the disposition of assets.

In addition to the finding that the constituent providers (SVH and TMC) and the consolidated entity (VMF/VHS) were related, the Administrator also finds that the consideration (assumption of liabilities) received for the depreciable assets was not reasonable consideration and does not support a finding that the transaction constituted a bona fide sale.

Regarding the consideration given for the transfer of SVH's assets, the record shows that SVH claimed assets with a net book value of $124,082,500 were transferred to the VMF pursuant to the assumption of liabilities of $26,581,012 (or approximately 21.42 percent of the total value). This resulted in a difference of $97,501,488 between the value of the assets and the value of the consideration received by SVH in exchange for the assets. Based on these fact, the record does not demonstrate that reasonable consideration was received for these assets.[46]

In addition, the Administrator notes that the Intermediary contended that the SVH's calculation of liabilities assumed should have been $56,236,012.[47] If a dollar to dollar value allocation of the assumed liabilities of $56,236,012 is first applied to the Provider's cash and current assets valued at $85,397,000, the amount of cash-based current and monetary assets alone (without considering the depreciable assets) were in excess of the transfer price by $29,160,988.[48] When this methodology is applied, none of the "purchase price" is allocated to the depreciable assets because of the disparity of the transfer price and the value of the asset. This methodology further demonstrates that this was not a bona fide sale but in essence constituted a donation of depreciable assets for which no loss can be claimed.

Likewise, with regard to TMC, the record shows that TMC claimed assets with a net book value of $191,632,467,000 which transferred to the VMF pursuant to the assumption of liabilities of $63,488,323 (or approximately 33.18 percent of the total value). This resulted in a difference of $127,874,144 between the value of the assets and the value of the "consideration" received by TMC in exchange for the assets.

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[46] Even the SVH's "fair market appraisal" (Intermediary Exhibit I-12), conducted after the transfer of assets and unverified by the Intermediary, shows a "business enterprise" value of $107,336,000 and individual assets of $77,279,500. While the later figure does not show cash and current assets, this amount alone is far in excess of the liabilities assumed.

[47] See Intermediary's SVH Position Paper at 5.

[48] See Intermediary's SVH Exhibit I-13.

Based on these facts, the record does not demonstrate that reasonable consideration was received for the assets.[49]

The Administrator notes that the Intermediary contends that the TMC's calculation of liabilities assumed should be $93,285,563.[50] If a dollar to dollar value allocation of the assumed liabilities of $93,285,563 is first applied to the Provider's cash and current assets valued at $121,740,532, the amount of cash-based current and monetary assets alone (without considering the depreciable assets) were in excess of the transfer price by $28,454,969.[51] When this methodology is applied, none of the "purchase price" is allocated to the depreciable assets because of the disparity of the transfer price and the value of the asset. This methodology further demonstrates that this was not a bona fide sale but in essence constituted a donation of depreciable assets for which no loss can be claimed.

Thus, with respect to this transaction, in order to find that any consideration was paid for the depreciable assets, a less than dollar-to-dollar allocation must be made to the monetary assets. When a dollar-to-dollar allocation is made to the current and monetary assets, the Providers in this case in fact disposed of their depreciable property for no consideration (i.e., donation). In conclusion, the Administrator finds that regardless of the methodology, this is not reasonable consideration required of an arms length transaction and bona fide sale. Thus, the transaction failes to meet the criteria required under 42 CFR§413.134(f) for a loss on the disposal of assets to be recognized.

In addition, the fact that the parties did not secure an appraisal prior to the transaction is also an indication that the Providers were not concerned with receiving reasonable consideration for the depreciable assets.[52] The Providers did not place the assets for sale in the open market to ascertain their worth also indicating that there was no good faith bargaining between the parties to establish the fair market value of the Providers' assets as an ongoing concern before the transaction. There is no documentation in the record that supports a conclusion that the assumption of

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[49] Even the TMC's "fair market appraisal" (Intermediary exhibit I-12), conducted after the transfer of assets and unverified by the Intermediary, shows a "business enterprise" value of $125,387,000 and individual assets of $107,929,000. While the later figure does not show cash and current assets, this amount alone is far in excess of the liabilities assumed.

[50] See Intermediary's TMC Position Paper at 6.

[51] See Intermediary's TMC Exhibit I-13.

[52] See e.g. Intermediary's Exhibit I-12 dated February 11, 1997.

debt was fair consideration for the SVH's and TMC's assets.[53] Thus, the Administrator finds that, as the transaction did not involve an arm's length transaction, the transaction was not a *bona fide* sale as required under the regulations and PRM for the recognition of a loss on the disposal of assets.

As a loss cannot be allowed in this case, the Administrator does not reach the issue of how to calculate the loss. However, as noted above, the issue of calculating a loss does point out certain anomalous results when applying certain methodologies when there has been no bona fide sale. The Administrator concludes that this problem further supports a finding that no loss is to be calculated under these facts of this case.

Consequently, the Administrator finds that, not only was the transaction between related parties, but that there was no bona fide sale as required under 42 C.F.R. § 413.134(f).

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[53] The record also does not show that the parties were engaged in arms length bargaining, reflective of a bona fide sale of the assets, over the potential Medicare loss on disposal of assets claim. The Medicare loss on disposal claims, if the Providers were to be successful, are not calculated in the worth of the assets transferred.

DECISION

The decision of the Board is modified. The Board's finding with respect to SVH is reversed in accordance with the foregoing opinion. The decision of the Board with respect to TMC is affirmed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

Date: 4/23/07

/s/
Herb B. Kuhn
Acting Deputy Administrator
Centers For Medicare & Medicaid Services

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

Date: _______________ ______________________________________

Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services