CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Meridian Hospitals Corporation **Group Costs Group** **Provider** **vs.** **Blue Cross Blue Shield Association/** **Riverbend Government Benefits** **Administrator** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 12/31/96** **Review of:** **PRRB Dec. No. 2003-D35** **Dated: July 02, 2003**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), [1] 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 parties were notified of the Administrator's intention to review the Board's decision. The Intermediary submitted comments, requesting reversal of the Board's decision. Comments were also received from the CMS Center for Medicare Management (CMM) requesting reversal of the Board's decision. The Providers submitted comments, requesting that the Administrator affirm the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's adjustments disallowing the Providers' claimed losses on disposal of assets due to a change of ownership were proper.[2]

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[1] Formerly called the Health Care Financing Administration (HCFA).

[2] 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

The Board held that the Intermediary's adjustments were improper. The Board found that the Providers were unrelated under §413.17 and §413.134. Observing that there was no dispute that a consolidation was formed in this case, the Board noted that §413.134(k)(3)[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 Meridian was formed January 1, 1997 through the consolidation of three hospitals. Meridian acquired all of the constituent hospitals' assets and assumed all of their liabilities.

The Board pointed out that §413.134(k)(3) states that, if a consolidation is between unrelated parties, as specified in §413.17, the assets of the provider corporation may be revalued. Thus, the Board looked to 42 CFR 413.17 to determine whether the consolidation was between unrelated parties. The Board acknowledged that CMS Program Memorandum A-00-76 (Oct. 2000), stated 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 than whether the constituent corporations were related.

However, the Board concluded from "the plain language of the consolidation regulation" that the related party concept applies only to the entities that are consolidating, and further that the Secretary's intent in drafting the regulation 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 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[4] 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. The Board, therefore, concluded that the

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scrapping. Conforming modifications to the applicable regulation made December 1, 1997 the effective date for implementing the new rule.

[3] (2002) Originally codified at 42 CFR §405.415 (l). For purposes of this decision, the Code of Federal Regulation designation for 2002 will be used.

[4] The Board cited to only one letter, dated May 11, 1987, from HCFA's Director of the Division of Payment and Reporting Policy, Office of Reimbursement Policy.

related party principle should not be applied to the consolidating parties' relationship to the new entity.

The Board also found that the consolidation was a bona fide transaction consolidating the constituent hospitals (three independent hospital corporations), into one new entity. The Board emphasized that the consolidation was a result of arms-length bargaining. The concept of three constituent hospitals forming into a new corporation, the Board concluded, bars the type of arms-length bargaining between the constituent and new entities which the Intermediary contended was necessary.

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 §413.134(k)(3). The Board also acknowledged the Administrator's reversal of its decision in Cardinal Cushing Hospital/Goddard Memorial Hospital[5] (Cushing), 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.

The Board turned to the Providers' claim that they qualify for Medicare reimbursement of the loss, after revaluation. In this regard, the Board noted that both the Providers and the Intermediary had plausible interpretations of §413.134. The Board stated that the Providers maintained that subsection (f) requires an adjustment to a provider's allowable cost, if a disposal of depreciable assets results in a gain or a loss; in contrast, the Intermediary argued that §413.134(k) addresses both mergers and consolidations, but expressly applies subsection (f) only to mergers, implying that it does not apply to consolidations. Reviewing the history of the regulation, the Intermediary Manual and the two CMS letters, referenced above, led the Board to conclude that CMS intended a recognition of a gain or loss to be realized.

However, despite this conclusion, the Board found that there is no clear application of the recognition of a loss to consolidations in either the Medicare regulations or the Intermediary Manual. The Board noted that §413.134(k)

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[5] PRRB Dec. No. 2003-D6, *rev'd* CMS Admr. Jan 29, 2003.

instructs revaluation in accordance with paragraph (g), which addresses the establishment of cost bases on purchases of facilities. While the paragraph does not expressly deal with consolidations, the Board noted that it does address the typical bona fide sale transaction. After an analysis of the paragraph, the Board concluded that it must examine the evidence to decide the availability of an "acquisition cost" or a "fair market value" of the depreciable assets in this appeal.

The Board noted that the Providers argued that the liabilities assumed by the new corporation should be treated as consideration determined through arm's-length bargaining, and, thus, as the acquisition costs, to be allocated among all of the assets acquired. However, the Intermediary contended that the fact that there was no motivation to maximize sales price indicated that the bargaining was not arms' length; the regulation contemplated an acquisition cost to be determined through arms-length bargaining would be likely to produce fair market value. Moreover, the Board added, the Intermediary emphasized that the gain/loss regulation was not amended when the additional sections on consolidation and merger were added to §413.134(k). 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 lack of a market for provider facilities were persuasive that the Providers incurred a genuine financial loss on the consolidation. The Board also found that such evidence supported the Providers' 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 Principles 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 §413.134(f).

With regard to the calculation of the loss, the Board considered various allocation methodologies proposed by the Providers, 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 all of the Providers'

assets, using the method in §413.134(f)(2)(iv). The Board remanded this matter to the Intermediary for the proper calculation of the loss.

SUMMARY OF COMMENTS

CMM Comments

CMM requested reversal of the Board's decision. CMM stated that the Board incorrectly held that the Providers were entitled to claim capital reimbursement as a result of losses though sales of their facilities upon consolidation. CMM stated that each transfer of depreciable assets by the constituent hospital corporations to the consolidated entity was between related parties and each did not involve a bona fide sale. As the same legal issue was presented in Cushing, CMM attached and incorporated by reference its comments in that case.

In Cushing, CMM argued that the Board incorrectly held that the Providers were entitled to claim capital reimbursement as a result of "losses" through "sales" of their facilities upon consolidation. CMM disagreed with the Board's interpretation of 42 CFR § 413.134(k)(3), and argued that the better reading that "between two or more corporations that are unrelated" in (k)(3)(i) should include the relationship between the constituent corporations and the consolidated entity. CMM reviewed the history of both (f) and (k) of the regulation and found that the February 5, 1979 rule was intended to clarify what constituted a transfer of stock corporations assets, and not to set forth any new policy, including any new policy on losses on depreciation, where a transfer takes place in the context of a merger or consolidation.

CMM also commented that the Board erred in finding that the Program Memorandum A-00-76 is not applicable to this case because it was contrary to the plain language of §413.134(k)(3)(i). CMM further argued that even if the Board is correct, the Program Memorandum nevertheless should be given force and effect. The regulation upon which the board relies is limited to for-profit organizations. CMM commented that the Administrator should find that each Provider has failed to carry its burden that the transaction was not a related party transaction, and each Provider's claimed loss should be denied on this basis.

With respect to this particular case, CMM stated that each of the constituent hospital corporations maintained a significant presence on the board of directors of the consolidated entity (eight, eight and eight, respectively, out of 24 board members) representing 33 1/3 percent from each of the three hospitals. Notably, while the financial strengths of the constituent hospitals were not equal, each nevertheless retained roughly the same amount of representation on the new board

of directors. Thus, the record supports a finding that the Intermediary's disallowance was proper as the parties were related abd thus there was no bona fide sale.

CMM further addressed the issue of a bona fide sale, noting that no documentation was submitted to demonstrate that arm's length bargaining had occurred. For example there was no evidence that any of the hospitals engaged in any hard bargaining with AHS, or that any of the hospitals made any serious effort to sell its assets to any other entity. The parties did not secure appraisals of the assets prior to the consolidation. Finally, §104.24 of the Provider Reimbursement Manual defines bona fide sale as an arm's length transaction for reasonable consideration. In this case, none of the hospitals' sold their depreciable assets for anything remotely approaching reasonable consideration. In fact, the record shows that two of the three hospitals transferred their depreciable assets for no consideration whatsoever. CMM noted this finding was true regardless of whether one accepts the appraisals as accurate. CMM commented that the appraisal valuations were unreasonable as they represented considerably less than the hospitals' current and monetary assets alone.

Intermediary Comments

The Intermediary requested that the Administrator reverse the Board's finding that a loss on disposal of assets is allowable and render moot the Board's remand for calculation of the loss. The Intermediary argued that the Administrator's rationale in Cushing, where the Board's decision favoring a loss on a consolidation was reversed, fully supports the requested modification in this case.

The Intermediary's overall criticism of the Board's decision was that the Board allowed the mechanics of executing a complex transaction define the meaning of the transaction. The Intermediary explained that the constituent hospitals recognized a number of future competitive advantages in operating as one organization, although it was difficult for the governance of the individual hospitals to surrender their autonomy for the collective benefits of the new corporation. The primary output of the extended process that began with the preliminary decision to join together was to define the structure of the new parent and how the separate powers of the three hospitals would transition into a unified governance.

Furthermore, the Intermediary maintained that the constituent hospitals gave no serious thought to exchanging their community health care roles for the highest value their assets would bring in an open marketplace transaction. The means selected to realize the constituent hospitals' goals was the consolidation, under which they could combine existing operations to create a new corporation

utilizing the mutually agreed-upon governance structure. As a matter of law, when two or more corporations consolidate into a newly created corporation, all existing assets and liabilities are transferred.

Although the consolidation was the means by which the hospitals realized their goal of joining together, the Providers were able to convince the Board that, for Medicare reimbursement purposes only, the long complicated effort should be viewed as the economic equivalent of the sale of all assets for consideration that was equal to existing liabilities. Since the Hospitals were solvent, large losses resulted from the disposition of the depreciable assets. However, the Intermediary contended, that narrow view mischaracterized the process and was not supported by Medicare law or any objective business analysis. The Intermediary's argued that the consolidation was not a bona fide sale, but rather was the transfer of assets between related parties. The outcome is that no loss was incurred.

The Intermediary quoted several paragraphs of the Board's decision.[6] From these paragraphs, the Intermediary observed that the Board understood the importance of accurately measuring the actual consumption of depreciable assets which are being transferred. In addition, the Board observed that the "financial outcome" advocated by the Providers, in which fair market value issues are ignored, could not be explained by the Providers' witnesses (former CMS officials'), nor could the fact that, under that approach, the healthier the balance sheet, the larger the loss. The Intermediary concluded that, in spite of the Board's recognition of these problems, the Board felt that it was bound by a regulatory directive to adjust depreciation when unrelated Medicare providers consolidated. The Intermediary maintained that, because such a directive does not exist, the Providers' case must fail.

Turning to GAAP and the Medicare rules, the Intermediary noted that, unless there is a regulation or Manual provision indicating otherwise, GAAP will be followed. In this case, the authorities coming into play are the regulation at §413.134(k), and the Intermediary Manual section on changes of ownership (CHOW) at §4500, et. seq., which incorporated most of the principles in Accounting Principles Board (APB) No. 16 of GAAP, discussing business combinations. Prior to the addition of subsection (k), and thus, in place when subsection (k) was adopted, §413.134 had sections providing for a gain or loss on the disposition of depreciable assets and a revaluation of those assets after a bona fide sale. Under APB No. 16 (also in place prior to subsection (k)) analysis, a determination must be made as to whether a transaction was a "pooling of interest" or a "purchase." A "pooling of interest" was valuation neutral; the

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[6] See Board's Dec., pp. 19 and 24.

assets, liabilities, and equities of the participating businesses would be added together, with no write-up or write-down. A "purchase" occurred when one participant purchased another. The Intermediary observed that the APB went on to explain that, in a purchase business combination, one company is clearly the dominant and continuing entity, and, one or more other companies ceases to control its/their own assets and operations.

The Intermediary argued that the bona fide sale concept in the regulation is consistent with the APB "purchase" concept, where there is a dominant and continuing entity (buyer), and entities surrendering control of their assets (sellers). The bona fide sale concept is not consistent with a pooling of interest. When §413.134(k) was published, the preamble observed that certain problematic transactions were treated as purchases under the APB, but should not be revaluation transactions for Medicare. The outcome of the regulation was as follows: consistent with APB No. 16, a purchase which is executed as a merger would cause a revaluation/gain or loss; but inconsistent with APB No. 16 principles, a purchase executed as a stock acquisition would not give rise to a revaluation/gain or loss calculation; and, also inconsistent with APB No. 16, a purchase executed through a stock purchase followed by a merger of the two entities would not invoke a revaluation/gain or loss process.

Reviewing the regulation and the preambles indicates that there was extensive discussion on mergers, but little on consolidations. The Intermediary pointed out that the Board had dismissed an Intermediary observation that, while §413.134(f) was cross-referenced in the later merger section of the regulation, there was no such cross-reference in the consolidation section, leading to the conclusion that, if a consolidation can trigger revaluation/gain or loss, then the more detailed analysis of mergers has to be applied. The CHOW rules also follow the regulation position on when a purchase under APB No. 16 will be given the same reimbursement treatment as a bona fide sale. Notably, the Intermediary stated, the Certified Financial Statements of the Providers in this case reported the transaction as a pooling of interests and recorded no loss, and yet, a pooling of interests is not a purchase under APB No. 16 and is not a bona fide sale under Medicare. Moreover, from an asset valuation standpoint, as reported on the new and participating entities' Financial Statements, which were not challenged, no revaluation took place.

Continuing on, the Intermediary argued that the Board accepted the Providers' unsupported conclusion that, under §413.134(k)(2)-(3), regardless of how a business combination is defined and reported pursuant to APB No. 16, it will require a revaluation/gain or loss process as long as the uniting corporations are deemed unrelated at the time of negotiations. Nowhere in Medicare law or policy is there support for the conclusion that a "pooling of interests" under the APB

must be transformed into the equivalent of a sale of the net book value of the assets for the assumption of total liabilities. No such intent is expressed or implied. The only proper finding in this case is that no reimbursable loss was suffered by any of the consolidating parties.

Turning to the calculation issues in this case (were a loss to be determined), the Intermediary argued that the methods of valuing the transactions to compute the loss, in the Board's decision and elsewhere in the record, have either maximized the loss on the depreciable assets, or underestimated the value of cash and other assets. While the Intermediary recognized APB No. 16 as the best tool for valuation, it also found problematic the fact that the APB was written specifically for stock companies, where stockholders typically receive stock interests in the purchasing entity or other consideration. The best analogy in this case is to recognize the intangible value of the constituent hospitals' participation and execution of the consolidation, in exchange for the negotiated power and participation in the new entity. Those benefits are not completely different from a corporation whose stockholders receive stock in the company which purchases it.

The Intermediary pointed out that the APB measures non-cash consideration against the fair market value of the assets of the purchased entity, and the CHOW also does not preclude valuing the receipt of intangibles. The practical effect of this methodology is to identify the ultimate loss as the difference between the fair market value of the depreciable assets and the net book value. The Intermediary further stated that, although the Board recognized that there was a drop in value of the Providers' assets, nothing in the record clearly measures the amount of the decline. Thus, the Intermediary recommended, if the Provider Group is successful in demonstrating its entitlement to a loss on assets, that the loss should be based on an objective determination of the decline in asset values, rather than the arbitrary measure of assets to liabilities, which results in an inaccurate end result.

Providers' Comments

The Providers commented, requesting that the Administrator affirm the Board's decision. The Providers stated that it would be arbitrary and capricious for the Administrator to find that the consolidation was a transaction among related parties in opposition to the plain meaning of the regulation and manual provisions. The Providers disagreed with the Intermediary interpretation that the regulations required that the related party rules be applied to both pre-consolidation and to post-consolidation. The Providers argued that the related party regulations applied only to pre-consolidation transactions. To support this position the Providers cited to North Iowa Medical Center v. Department of Health and Human Services, 196 F. Supp. 2d

784 (N.D. Iowa 2002), which held that the parties were not related post-consolidation and that the transaction was an arms-length, bona fide sale.

To further support the Providers' position that the related party concept applied only to pre-consolidation transactions, the Providers relied on interpretive guidelines published in the Intermediary Manual at §§ 4502.7 (Consolidation) and 4502.10 (Corporate Reorganization) to argue that Medicare permits a revaluation of assets when a consolidation is between unrelated parties. The Providers stated that the importance of the relationship of the parties prior to the transaction cannot be overstated. This distinction may be understood by comparing § 4502.7 defining consolidation, to § 4502.10 defining corporate reorganization. After a transaction is completed, the assets, the management, the ownership are all stirred together, by definition. This is true in the case of reorganization, consolidation, and in many mergers. According to the Manual however, the crucial fact is the relationship of the parties prior to the transaction. When they are related both before and after, as in the case of a reorganization, no gain/loss is allowed for the "seller" under § 4502.10. Where they are unrelated prior to the transaction, as in the case of a consolidation, "a gain/loss to the seller…" is computed.

The Providers also took issue with the Administrator's decision in Cushing wherein the Administrator cited to Internal Revenue Service (IRS) rules to show that Medicare's policy of not recognizing a gain or loss when the transaction constitutes reorganization is also consistent with other government regulations. Finally the Providers commented that the Intermediary's use of CMS Program Memorandum A-00-76 was invalid as it represents retroactive rulemaking because it was issued without the benefit of the rulemaking process. To support this position, the Providers noted that the new corporation was formed in January of 1997, and that Congress repealed 42 CFR §413.134 prospectively, effective December 1, 1997.

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 therefrom 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 CFR §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 CFR §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 CFR §413.130) for plant and fixed equipment, and for movable equipment.

Title VI of the Social Security Amendments of 1983[7] 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[8] 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 "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.

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[7] Pub. Law 98-21.

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

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.[9]

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.

The regulation at 42 CFR § 413.130 explains, 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

[9] 44 Fed. Reg. 3980 (Jan 19, 1979).

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. [10]

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. [11] (Emphasis added.)

These rules have been set forth at 42 CFR §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:

> (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

[10] 41 Fed. Reg. 35197 (August 20,1976) "Principles of Reimbursement for Provider Costs: Depreciation: Allowance for the Depreciation Based on Asset Costs." (Proposed rule.)

[11] 44 Fed. Reg. 3980. (1979) "Principles of Reimbursement for Provider Costs."(Final rule.)

> 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, Section 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. [12]

Paragraph (f)(3) addresses gains or losses realized from sales within 1 year after the provider terminates from the program, while §413.134(f)(4) addresses exchange trade-in or donation[13] of the asset stating that: "[g]ains or losses realized 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.

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

[13] A donation is defined in §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 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.

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,[14] 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 CFR §413.134(k)[15] 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:

> (k) *Transactions involving a provider's capital stock*—
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> ****
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> (3) *Consolidation*. A consolidation is the combination of two or more corporations resulting in the creation of a new corporate entity. 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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> (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. (Emphasis added.) [16]

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[14] 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.

[15] (2002) Originally codified at 42 CFR §405.415(l).

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

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

B. Related Organizations

Finally, 42 CFR § 413.134 references the related organization rules at 42 CFR§ 413.17. The regulations at 42 CFR §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.

Consistent with the Act and the regulations, the above principles are set forth in the Provider Reimbursement Manual or 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 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).[17]

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

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

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(k) 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 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 CFR 413.134(k) 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 CFR 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 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 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:

> whether 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.

The PM stated that the term significant, as used in the PM has the same meaning as the term significant or significantly, in the regulations at 42 CFR 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, the PM 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 413.134(k) and as defined in the PRM at section 104.24. The PM stated that the regulation at 42 CFR 413.134(k) 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 (§405.17) 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.[18] 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 before and after the termination.[19] Thus, the PM 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 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(k) that refers to "between two or more corporations that are

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[18] 42 Fed. Reg. 45897 (1977).

[19] 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.)

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.[20] 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:

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[20] See also, e.g., N.J. Stat. 54A:5-1(c) a "party to a reorganization includes a corporation resulting from a reorganization, and both corporations in the case of a reorganization resulting from the acquisition by one corporation of stock or property of another."

> 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 a 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,[21] 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,[22] 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.[23]

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 the constituents and ownership interests continue. The pooling of

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[21] 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."

[22] 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).

[23] The Provider's witness at the hearing pointed out that APB No. 16 and the pooling of interest provision was rescinded, leaving only the "purchase" method of accounting for business combinations. The CHOW does not reflect this change. Moreover, while FASB No. 141 did replace APB No. 16 effective June 2001, at the present, not-for-profit (NFP) organizations are excluded from the scope of FASB No. 141.

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.[24] 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.[25]

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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[24] 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).

[25] 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.[26] 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.[27] (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."[28] 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 A and B transfer assets to C, a new corporation, in

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[26] 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.")

[27] 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).

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

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."[29]

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.

II. Finding of Facts and Conclusion of Law.

This particular case involves a loss on sale claimed by three hospitals as a result of their consolidation to form a "new corporation." Each of the constituent

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[29] 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)).

Hospitals filed a terminating Medicare cost report for the fiscal year ending (FYE) December 31, 1996, which included a depreciation adjustment that recognized a loss on disposal of assets resulting from the consolidation. Upon audit of the cost reports and the loss calculations of the Providers, the Intermediary issued Notices of Program Reimbursement (NPRs) denying the claimed losses.

In this particular case, the record shows that three hospitals consolidated to form a new corporation and that, simultaneously, the three parent corporations of the three hospitals consolidated to form a new parent corporation for that new consolidated hospital corporation. The documents in the record include the Letter of Intent, dated March 4, 1996, entered into by the parent corporations and the constituent hospitals;[30] the Agreement and Plan of Consolidation entered into by the parents which included: a) Plan of Consolidation of Parents, b) Plan of Consolidation of Hospitals, dated June 26, 1996;[31] the Certificate of Consolidation of Parents filed December 31, 1996 and Certificate of Consolidation of Hospitals, filed December 31, 1996, with attachments;[32] and the By-laws of Meridian Health System, adopted January 1, 1997.[33]

The record shows that the assets of Jersey Shore Medical Center (Jersey Shore), Riverview Medical Center (Riverview) and Medical Center of Ocean County (MCOC) (collectively referred to as the constituent Hospitals) were transferred to a newly created corporation, Meridian Medical Center (formerly referred to as Central Jersey Hospital, Inc. (CJH) and later changed to Meridian Hospital Corporation (MHC))(the consolidated hospital corporation).[34] As a result of the consolidation, the consolidated hospital corporation, MHC, was vested with the real and personal property of the constituent Hospitals and assumed all of the obligations and liabilities of each of the consolidated corporations

The respective constituent Hospitals' sole members and parents were Modern Health Affiliates, Inc., (MHA), the parent corporation of Jersey Shore; The Ocean Health System, Inc., (OHS), the parent corporation of MCOC; and Riverview Healthcare Services Corporation, (RHSC), the parent company of Riverview (hereafter referred to as the constituent parent corporations).[35] The new parent corporation of the new consolidated hospital corporation (MHC) was Meridian

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[30] Provider Exhibit P-1.
[31] Provider Exhibit P-2.
[32] Provider Exhibit P-3.
[33] Provider Exhibit P-14. The record does not appear to have included the By-laws of Meridian Medical Center.
[34] See Provider Position Paper n.2.
[35] Under 42 CFR 413.17, the 'parents" are related parties to the respective hospital corporations.

Health System (MHS)(hereafter referred to as the consolidated parent corporation).[36]

Notably, pursuant to the parents' Agreement and Plan of Consolidation, the new consolidated parent corporation board of trustees was to consist of five members elected by each constituent parent, the chief of staff/president of each hospital and the president and chief executive officer of the new parent corporation.[37] The Agreement and Plan of Consolidation provided for a similar appointments as the board of trustees with respect to the new consolidated hospital entity formed as a result of the hospitals' consolidation.[38]

The Agreement also provided that, although the separate existence of the constituent hospitals' parent corporations would cease, "the closing of the Parent Consolidation shall not cause the three separate foundations to lose their separate existence, nor prevent the recipients of their financial support form continuing to

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[36] Although the Agreement stated that the constituent parents would consolidate to form the entity Central Jersey Systems, the name of the consolidated corporation was changed to Meridian Health Systems (MHS) with the filing of the Certificate of Consolidation.

[37] Provider Exhibit P-2. Section 2.5 of the Definitive Agreement provided that the Board of Trustees of the newly formed Parent consist of the following:

(i) 15 non-physician members, 5 elected by each of Parent.
(ii) Chief of Staff/President of the Medical Staff of each Hospital, ex-officio with vote; and
(iii) President and Chief Executive Officer of CJS, ex-officio with vote.

See also Provider Exhibit P-14, MHS By Laws; Provider Exhibit P-3, Certificate of Consolidation of Parents, Exhibit A - Plan of Consolidation, Schedule A showing initial Board members of MHS (identical to those of the newly created hospital corporation.)

[38] See Provider Exhibit P- 2. Section 3.4 of the Definitive Agreement provided that the Board of Trustees of the newly formed Hospital shall consist of the following:

(i) 18 non-physician members, 6 elected by each Hospital.
(iv) Chief of Staff/President of the Medial Staff of each Hospital, ex-officio with vote; and
(iii) President and Chief Execute Officer of CJS, ex-officio with vote.
(v) President of CJS Hospital ….if such person is not also the President and Chief Executive Officer of CJS.
(vi) President of the CJS Medical Staff

be the facilities and services located in the communities served by their respective affiliated Hospitals."

The Plan of Consolidation of the hospitals and the new parent corporation By-Laws, [39] among other documents, showed that the new hospital and parent corporation were created to, inter alia, establish, maintain, sponsor, and promote activities relating to the improvement of human health and rendering of care to the sick or injured. Thus, the purposes of the new hospital and parent corporation were similar to the purposes of the constituent hospital corporations and parents.

The record shows that, in fact, a significant number of members of the new MHC governing board were from the constituent hospitals' governing boards and/or were appointed by the constituent hospitals, (eight each or 33 1/3 percent of the board from each of the three hospitals), showing that each Provider retained and continued to have a significant control of its asset.[40] Post-consolidation, each Provider had approximately a 1/3 control over the combined assets of three hospitals.

The Administrator finds, applying the foregoing provisions to the facts of this case, that the Providers are not entitled to a loss on sale. A significant number of members of the consolidated hospital corporation were appointed and/or served on the former governing hospital boards (33 1/3 percent, respectively), showing that each hospital retained and continued to have a significant control of its asset. The Administrator finds that, for each hospital, the post-consolidation 1/3 control of the board was comparable to the pre-consolidation control and interest over 100 percent of one hospital.

These facts evidence a continuity of control between the constituent hospitals and the consolidated hospital corporation. There was also a continuity of business enterprise and purpose between the constituent hospitals and the consolidated hospital corporation. In addition, these facts also evidence a continuity of control between the constituent parents and the consolidated parent along with a continuity of business enterprise and purpose between the constituent parents and the consolidated parent.[41] The Administrator finds that the record contains

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[39] The By-laws of MHC do not appear to have been made part of the record.

[40] See Intermediary Exhibit I-6 showing 8 members respectively from each of the constituent hospitals forming the Board of Trustees for MHC. See also Provider Exhibit P-3, Certificate of Consolidation of Hospitals, Exhibit A-Plan of Consolidation, Schedule A-Initial Board of Trustees for MHC (formerly MMC). (identical to those of the newly created parent corporation.)

[41] The parents' "Agreement and Plan of Consolidation" and "Plan of Consolidation" (with attachments showing the initial board appointments), show

compelling evidence on the relatedness of the constituent hospitals and the consolidated hospital as these facts represent "significant" control. The transferors of the assets were also the transferees of the assets. Thus, based on the facts of this case, the Administrator finds that the parties were related according to 42 CFR § 413.17 and a loss on the disposal of assets cannot be recognized under Medicare.[42]

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 the constituent corporations same interests have been but recast in a different form only and, thus, a loss has not actually been incurred by the constituent hospital corporations that can be recognized by Medicare under § 1861(v)(1)(A) of the Act.[43]

The Board criticized the examination of IRS principles applicable to statutory reorganizations citing that the Administrator in Cushing had not explained the characteristics that converted a consolidation, executed strictly under State law, into a mere reorganization. Instead, the Board concluded that all mergers and consolidations are to some extent reorganizations and that the Agency decided to limited the related party rule to the constituent hospitals, which was binding in this case.

The Administrator finds that, as noted above, the common criteria between IRS rules and Medicare rules is that a transaction is treated similar to, or as, a reorganization (in that no gain or loss is recognized), regardless of the transaction title, when there is a continuity of interest or control between the constituent corporations and the new corporation.[44] That is, evidence of a continuity of

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continuity of control between the constituent parent corporations and the consolidated parent corporation similar to that of the constituent hospitals and consolidated hospital corporation.

[42] The Providers reported the transaction on their financial statements as a pooling of interest under APB No. 16 (i.e.. continuation of ownership). Consequently, the Providers showed no reported loss for any of the constituent hospitals on their certified financial statements

[43] Therefore, regardless of whether this transaction qualifies as a 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.

[44] As the Board noted, the transaction in this case was executed "strictly under State law." However, the terms "consolidation" and "reorganization" are also not

interest or control, is evidence that the entities have but recast its interest in another form and no actual loss has been incurred. Reasonable cost rules must be interpreted consistent with this economic reality.

The Administrator also notes that the Board also made several findings regarding the interaction of the various regulations on 42 CFR §413.134(k).[45] The Board found that the final rule at 44 Fed. Reg. 6913 (1979) conclusively limits the application of 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 (k). 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 (k). Moreover, the Board found that the specific provisions of paragraph (k) 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

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mutually exclusive under N.J. Stat. Section 54A:5-1c. (2003). In determining State income taxes, that provision states that "For purposes of this clause the term reorganization means: (i) a statutory merger or consolidation." The definition also includes under (iv) "A transfer by a corporation of all or a part of its assets to another corporation if immediately after the transfer, the transferor, or one or more of its shareholders (including person who were shareholders immediately before the transfer, or any combination thereof, is in control of the corporation to which the assets are transferred."

[45] 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.

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, he cannot limit his review to 42 CFR §412.134(k). Paragraph (k) 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 (k) did not modify or limit the general related party rules at §413.17 and does not address or modify the criteria for the recognition of gains or losses at paragraph §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.[46]

In addition, contrary to the Board's finding, the CMS policy of examining the relationship between the corporation 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

[46] 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."); 44 Fed. Reg. 6913 ("Only if the assets are transferred by means of a bona fide transaction between unrelated parties would revaluation be proper.")

illustrates circumstances when there is a consolidation that results in the calculation of a gain or loss. The PM 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.

In addition, the Administrator finds that the disposal 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). Applying the rules to the facts of this case, the Administrator finds that the transfer of the assets did not constitute a bona fide sale and the Providers failed to met any other criteria under which a loss on the disposal of assets will be recognized at §413.134(f). In this case, the record shows that the transferors of the assets were also the transferees of the assets. There is no evidence in the record of arm's length bargaining, nor an attempt to maximize any sale price as would be expected in an arms' length transaction.[47] Further, the consideration, or lack

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[47] Certain benefits of, or consideration given in, the transactions were intangibles, such as continuing control of the assets. However, as noted by CMM, regardless of the value of the assets transferred, all of the hospitals retained similar proportional control with respect to board members and management.

thereof, received for the depreciable assets supports a finding that the transaction did not constitute a bona fide sale.

Regarding the consideration given for the transfer of asset, CMS had previously determined, in conjunction with the appraisals submitted by the Providers, the following: Jersey Shore, current and monetary assets valued at $89,104,142 (per the financial statements) and non-current and monetary assets valued at $179,606,861, or total assets valued at $268,711,003, were transferred in exchange for $127,558,098 in assumed debt. In the case of Ocean County current and monetary assets valued at $41,367,736 and non-current and monetary assets valued at $101,066,529, total assets valued at $142,434,265, were transferred in exchange for $65,772,370 in assumed debt. In the case of Riverview, current and monetary assets valued at $94,429,610 and non-current and monetary assets valued at $81,525,546, or total assets valued at $17,955,156, were transferred in exchange of $71,742,630, in assumed debt. Collectively, the three constituent Hospitals assets were exchanged for just over $322 million below their value. These large discrepancies between the asset values and the consideration received reflect the lack of arm's length bargaining, and thus the lack of a bona fide sale.[48]

Further, CMS noted that allocating the consideration exchanged first to the substantial current and monetary assets (which would be required under the pooling method-where a dollar is worth a dollar), Riverview transferred its depreciable assets for no consideration whatsoever. Riverview transferred $94,429,610 in current assets in exchange for the assumption of Riverview's debt of $71,742,630; therefore, MHS paid no consideration for the $68 million worth of depreciable assets.[49]

The fact that a certificate of need was approved does not address whether this transaction was a bona fide transaction for purposes of reimbursement.[50] As noted in the Intermediary Manual at §4501, certification issues are distinct from

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[48] In addition, the Administrator agrees with CMM that the valuations of the appraisals were on its face unreasonable as the amounts represented considerably less than the hospitals' current and monetary assets alone. However, even based on these unreasonably low valuations, no consideration or significantly little consideration was transferred for the depreciable assets.

[49] It is not readily evident whether the Medicare receivables reported in the assets included the respective losses claimed on the cost report and at issue here.

[50] As part of the transaction, pursuant to the New Jersey Health Care Facilities Planning Act, the constituent Hospitals applied for a Certificate of Need (CON) with the State of New Jersey, Department of Health and Senior Services. The State approved the CON application by letter dated December 20, 1996. Provider Exhibit P-4.

reimbursement issues in evaluating a change of ownership. The fact that a certificate of need was approved addresses the certification question. As the IRS has recognized, while there are frequently legitimate business reasons for a consolidation it does not mean a loss will be recognized.

Finally, as a loss cannot be allowed in this case, the Administrator does not reach the issue of how to calculate the loss. However, as the Intermediary's comments noted, a review of the Board's decision on this issue highlights the anomalous results of finding that a loss is to be calculated in this case when there has been no bona fide sale. The Administrator concludes that this further supports a finding that no loss is to be calculated under the facts of this case.

The Board recognized that in this consolidation, there was no new consideration that exchanged hands as a result of the transfer of assets. Instead, only the assumption of liabilities were assumed by the new corporation. The Board also recognized that "despite intensive questioning by the Board and the Intermediary", the Providers' two witnesses were neither "able to articulate how the financing of a consolidation under the state law formula of transferring all assets and liabilities produces a better gauge of consumption of depreciable assets for Medicare services than the estimate under straight line depreciation." If one were to assume that the assumption of liabilities would be the basis for any loss, the Board recognized that a well run and performing hospital corporation may well experience a greater "loss" on depreciable assets, than the poor performing hospital corporation.[51]

This did not deter the Board from finding it was "bound by the regulations directives to adjust depreciation when unrelated Medicare providers engage in a consolidation." As reflected in the Board's own analysis, the Administrator finds that there is an obvious flaw in finding this consolidation constituted an event requiring application of a loss methodology that is applied to bona fide sales, where, in fact, there has not been a bona fide sale.[52] There is no explicit

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[51] See Board Decision, n. 30.

[52] As a result of the exclusion of non-profit combinations from the scope of FASB No. 141 (the replacement guidance for APB No. 16), the Financial Accounting Standards Board (FASB) has undertaken a project to develop guidance on combinations of not-for-profits organizations. In a June 20, 2003 update, the FASB also recognized the fact that non-profit business combinations can result in no dominate successor corporation (contrary to an underlying presumption on removing the pooling of interest under FASB No. 141). The FASB also noted that: "Combinations in which the acquiring entity is an NFP organization unlike combinations in which the acquiring entity is a business enterprise, cannot be assumed to be an exchange of commensurate value. Acquired NFP organizations

regulatory directive applying a special rule for consolidation of non-profits that rewrites the related party rules, the loss on sale rules, or the rules controlling the calculation of a loss that would allow this end result proposed by the Board.

Consequently, the Administrator also finds that, not only was the transaction between related parties but that there was no bona fide sale as required under 42 CFR §413.134(f) and that the Providers failed to meet any of the other criteria of paragraph (f) that would allow the calculation of a loss on sale.

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lack owners who are focused on receiving a return on …their investment…[T]he parent …of an acquired NFP may place its mission effectiveness ahead of achieving maximum price….” Such was similarly pointed out by CMS in its PM and the Intermediary in its comments in explaining why a consolidation of non–profits may result in no loss or, in the least, an inaccurate determination of a loss.

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: 8/19/03 /s/

Leslie V. Norwalk, Esq.
Acting Deputy Administrator
Centers For Medicare & Medicaid Services