CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Saint Clare's Hospital - Dover **Provider** **vs.** **Blue Cross Blue Shield Association/ Riverbed Government Benefits** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 9/30/94** **Review of: PRRB Dec. No. 2004-D38 Dated: September 13, 2004**

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)). Comments were received from the CMS Center for Medicare Management (CMM) requesting reversal of the Board's decision. The parties were then notified of the Administrator's intention to review the Board's decision. The Intermediary submitted comments requesting reversal of the Board's decision. The Provider submitted comments, requesting that the Administrator affirm the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's determination of loss on consolidation was proper.

The Board held that the Intermediary's adjustments were improper. Observing that there was no dispute that a consolidation was formed in this case, the Board

noted that §413.134(k)(3)[1] 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 under the terms of the transaction, the new corporate entity, Northwest, acquired all of the assets and assumed all of the liabilities associated with the operation of the two pre-existing entities. The Board found that the Provider was unrelated under §413.17 and §413.134 to the other consolidating hospitals.

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, it found that the plain language of the consolidation regulation was inconsistent with this policy.

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 a letter from a CMS official 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 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 (two independent hospital corporations), into one new entity under New Jersey 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 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

[1] (2002) Originally codified at 42 CFR §405.415(1). For purposes of this decision, the Code of Federal Regulation designation for 2002 will be used.

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[2] (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 Provider's claim that they qualify for Medicare reimbursement of the loss, after revaluation. In this regard, the Board noted that both the Provider and the Intermediary had plausible interpretations of §413.134. The Board stated that the Provider 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 that 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) 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 Provider 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'

[2] PRRB Dec. No. 2003-D6, rev’d CMS Admr. Jan 29, 2003.

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 Provider'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 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, 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 requested reversal of the Board's decision. CMM noted that the Administrator had previously ruled on this issue in several cases.[3] CMM stated that as the same legal issue was presented in these cases, CMM incorporated by reference its comments in those cases.

In the comments to the cited cases, CMM had 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 in those cases 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.

CMM also addressed the issue of a bona fide sale in those cases stating 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, or that 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

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[3] See Cushing, supra. See also AHS 96 Related Organization Costs Group (AHS), PRRB Dec. No. 2003-D34; Meridian Hospitals Corporation Group (Meridian), PRRB Dec. No. 2003-D35; St. Joseph, PRRB Dec. No. 2003-D64.

those cases, the hospitals' did not sell their depreciable assets for anything remotely approaching reasonable consideration. CMM submitted additional comments that further set out the facts of this case and the already stated law and policy that required that no loss on disposal of assets be allowed.[4]

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 also noted that the Administrator reversed the Board's decision in a series of previous cases. The Intermediary stated that in support of this request, it was relying on the analyses in the AHS, Meridian, and the St. Joseph case.

With respect to this particular case, the Intermediary noted that the governing board of Northwest (the newly created entity) had significant representation from Dover and Saint Clare's; and, that the "loss" was calculated by allocating liabilities of $67 million against assets of $101 million. In addition, the Intermediary stated that there was no evidence that the transaction was viewed as having a significant economic negative. A gross loss of $34 million or 33 percent of asset book value would raise eyebrows, if that was the true transaction. The Intermediary also noted that while there were extensive negotiations over structure and operation of Northwest, Dover and Saint Clare's never negotiated over value in any typical buyer-seller behavioral mode.

Moreover, the Intermediary, disagreed with the Board not putting 42 CFR 413.134(1)(3) in the context of the full depreciation regulation. The preamble to that regulation makes clear the commercial context (whether the participants were proprietary or "otherwise.) A consolidation (or merger) was a means of executing a value driven transaction. Similarly, if a seller is claiming a loss on sale (there is no reference anywhere to a loss on consolidation) the seller had a significant role in creating its buyer. That is a related party transaction.

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[4] The Provider submitted comments indicating that it believed the latter CMM comments were submitted late and should be, inter alia, struck and/or the Board's decision be allowed to stand. The parties and CMS have 15 days from receipt of the Administrator's notice of review to submit comments. The Intermediary and the Provider notices are sent by facsimile and the Intermediary and Provider Representative are called to confirm actual receipt of the facsimile. CMM is a large office separate and distinct, both physically and organizationally, from the Office of the Attorney Advisor. The notices for CMM are sent internally, for which a one-day internal receipt is presumed for administrative efficiency. Based on this presumption, the CMM comments were timely and properly included in the record.

The Provider commented, requesting that the Administrator affirm the Board's decision. The Provider first pointed out that the issue in this appeal is "determinations of loss on consolidation" not "a loss on a sale of assets" as was reflected in the October 3, 2003 notice of review letter. The Provider contended that consolidations are not required to satisfy the requirements of a bona fide sale of assets. In addition, the Provider continued to assert that the Intermediary disallowance may only be upheld based on the grounds relied upon in making the audit determinations.

The Provider further argued that the regulations adopted in 1979 require recognition of the Provider's loss on consolidation. The regulations and numerous agency interpretations reflect that where, as the subject case, two entities that are not subject to common control or common ownership, consolidate, the Medicare depreciable basis of their assets should be revalued and any related gain or loss recognized.

In addition, the Provider asserted that GAAP does not require a contrary result. GAAP is not applicable because recognition of gains and losses on consolidation is addressed in the Medicare regulations and interpretations. The Provider noted that while APB No. 16 is incorporated into the change of ownership provisions of the Medicare Intermediary Manual, it is not relevant in determination whether a gain or loss on consolidation is recognized. Finally, the Provider stated that, while CMS has relied on authorities addressing reorganizations to disallow loss claims, the transaction in the instance case was not a reorganization under Medicare program principles. As demonstrated in the Change of Ownership Manual, the term reorganization as used in health care does not include transactions involving two or more unrelated entities.

Finally, the Provider argued that CMM, in its comments, relied on three reasons for reversing the Board, all without merit. The Provider argued that this case is distinguishable form the earlier cases cited by CMM. In truth, the facts in this case are substantially more compelling for finding a loss on the disposal of assets. The Provider argued that this case shows testimony that the chief CMS policy proponent for the PM was the same policy person that allowed the loss to initially be claimed. This demonstrated that the PM was not in fact a clarification of earlier policy, but rather was a new policy. Regardless even in 2000 the Provider stated this CMS policy person recognized that gain or losses on some consolidations were proper and that he was considering the re-approval of the loss to Dover. The above information needs to be brought to the attention of the decision-maker.

The distinguishing facts of this case is that Dover after the consolidation was in fact a Catholic hospital and control was held by St. Clare and the parent member. In addition, St. Clare in this instance did not claim, nor did the intermediary allow any loss on the disposal of assets. All of Dover directors were rotated off of the post-

consolidated board after a reasonable period of transition. The appraisal supports the conclusion that fair market consideration was given for the Provider's assets. Finally the Intermediary, with the advice of CMS personnel, initially allowed the loss, unlike in other cases.

The comments of CMM reflect that it did not read the transcript or the Board decision properly. As the Board stated, in this case the consideration given did equate to fair market value. If the consideration must equate to the net book value of the asset in order to be bona fide, there would never be a finding of a bona fide transaction. The Provider concluded that the Administrator must acknowledge that in this case it is appropriate to recognize a loss on the consolidation.

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[5] 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[6] 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.[7] 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

[5] Pub. Law 98-21.

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

[7] 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.

> disposition, reimbursement for depreciation must be adjusted so that Medicare pays the actual cost the provider incurred in using the asset for patient care.[8]

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 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

[8] 44 Fed. Reg. 3980 (Jan 19, 1979).

> computation and treatment of gains and losses in determining reasonable costs.[9]

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.[10] (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 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:

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[9] 41 Fed. Reg. 35197 (August 20,1976) "Principles of Reimbursement for Provider Costs: Depreciation: Allowance for the Depreciation Based on Asset Costs." (Proposed rule.)

[10] 44 Fed. Reg. 3980. (1979) "Principles of Reimbursement for Provider Costs." (Final rule.)

> *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.[11]

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[12] 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.

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

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

[12] 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.

losses is generally only of interest to the prior owner,[13] 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)[14] 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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> ****
>
> (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.)[15]

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

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[13] 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.

[14] (2002) Redesignated from paragraph (1). Originally codified at 42 CFR §405.415(1).

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

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).[16]

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

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

> 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 principle 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.[17] 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.

[17] PM A-01-96 (Aug. 7, 2001) replaced A-00-76. The only change was a new discard date.

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 requirement that the term "between related organizations" include an examination of the relationship before and after a transfer 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 is consistent with early Medicare policy and the 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.

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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.)

Finally, this interpretation set forth in the PM is also consistent with the language of 42 CFR 413.134(k) 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 has reasonably applied the related parties rules in requiring an examination of the relationships of the parties to the consolidation: 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 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,[20] 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,[21] 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.[22]

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 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

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[20] 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."

[21] 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).

[22] Effective June 2001, APB No. 16 and the pooling of interest provision were rescinded, leaving only the "purchase" method of accounting for business combinations. The CHOW does not reflect or adopt 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.

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.[23] 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.[24]

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, reorganizations and reorganizations may involve more than one corporation.[25]

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[23] 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).

[24] 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).

[25] See also Black's Law Dictionary (7th Ed. 1999) recognizing IRS definition of a reorganization used interchangeably with merger and consolidation. ("A reorganization that involves a merger or consolidation under a specific State statute.")

For example, a consolidation where the predecessor corporation board continues 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 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.[26] (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."[27] 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 exchange for all of C's stock, the stock received is not a basis for calculation of a

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[26] 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 case illustrates the continuity of interest concept, the Administrator notes that the Medicare program does not recognize a loss on sale as a result of the transfer of stock regardless of the relationship of the parties.) Case law 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).

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

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."[28]

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 on reorganizations or consolidations between related parties 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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[28] 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.

This particular case involves a Provider's claim for a loss on the disposal of depreciable assets as a result of a consolidation. The transaction involved the Provider, Dover General Hospital and Medical Center, and another hospital, Saint Clare's Riverside Medical Center (Saint Clare's) which were consolidated to form a new entity, Northwest Covenant Health Care System (Northwest).[29] The Provider, Dover, was a not-for-profit community hospital whose sole member was Lake Area Health System. Saint Clare's was a Catholic hospital corporation whose sole member was the Sisters of the Sorrowful Mother Health Care Ministry Corporation.

In 1993, these two hospitals formed a joint task force to study how to work together to better serve the community. In September 1993, the joint task force recommended consolidating the hospitals to form a new health care system.[30] That recommendation was approved by both Boards in October 1993. State

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[29] A third hospital, Wallkill Valley General Hospital Association was merged into St. Clare Riverside Hospital. See Exhibit P-6, Agreement to Consolidate at p.10 The details of that transaction are not part of this record; see also Exhibit P-10, 1999 Corporate By-laws of St Clare's Hospital (the consolidated entity); Section 1.1. "The hospital originates from the consolidation or merger of the former St Clare's Hospital Riverside, Wallkill Valley General Hospital Association and Dover General Hospital and Medical Center."

[30] Exhibit P-2. Joint Task Force Resolution-September 29, 1993. This document shows that the Board of Trustee for the Provider and St. Clare's entered into discussions to "assess the status of their respective institutions and to evaluate alternatives for the development of an integrated delivery network." The Board of Trustee for the Provider and St. Clare's appointed a joint task force to assess, evaluate alternatives and make a recommendation to the boards. The joint task force met and "evaluated information concerning the hospitals, industry trends, market environment, payer/reimbursement systems, new or expanded services, community needs and potential savings and other relevant input." The joint task force concluded that it would be in the best interest of the community served by Dover and St Clare's to consolidate the two institutions. The resolution shows that the joint task force would "continue to exist as a transitional committee to address issues as they arise concerning the consolidation, to coordinate the efforts necessary to consolidate the institutions and to report to the individual boards the status of the consolidation and to seek approval of any action requiring Board approval…."

certifications of need were secured the following year[31] and the terms of the consolidation were adopted by the respective Board of trustees. On September 29, 1994, the Boards adopted appropriate resolutions and a consolidation agreement was entered into effective October 1, 1994, in which Saint Clare's and Dover were consolidated into Northwest Covenant Health Care System, which was incorporated October 1, 1994.[32] At that time both hospital corporations ceased to exist as separate corporations. The Sisters became the sole member of Northwest. Lake Area Health System was dissolved. The Board of Trustees of Northwest consisted of 42 members from both boards of Saint Clare and Dover. Northwest operated the hospitals under the name Northwest.[33] A single medical staff and medical by-laws served both hospitals.[34]

The Administrator finds applying the foregoing provisions to the facts of this case, that the Provider is not entitled to a loss on disposal. The Administrator finds that the transaction involved a related party transaction because of the relationship between the Provider and the post-consolidation corporation. The record shows that the post-consolidation corporation governing board included 21 members appointed from the Provider's former board and 21 members appointed from the pre-consolidated St. Clare board for a total of 42 post-consolidating governing board members.[35] The Administrator concludes that a significant number of the members of the Provider's former board were appointed to the new governing board and that the Provider retained and continued to have a significant control of its asset. Post-consolidation, the former Board members of the hospital had approximately a 1/2 control over the combined assets of at least two hospitals.

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[31] The State's determination on the certificate of need application to consolidate was issued by letter dated August 17, 1994. Exhibit P-4 The letter noted that: "There is no purchase or sale of assets as a result of this consolidation."

[32] A Certificate of Consolidation was filed September 29, 1994. Exhibit P-8. A Plan of Consolidation was dated September 29, 1994. Exhibit P-8. A joint resolution, was adopted September 29, 1994, involving various interested parties of both providers. Exhibit P-6.

[33] The former Saint Clare was operated as Northwest Covenant Health Care System-Denville Division (now know as Saint Clare's Hospital-Denville) and the former Dover General Hospital and Medical Center (the Provider) was operated under the name Northwest Covenant Health Care System-Dover Division (now know as Saint Clare's Hospital-Dover).

[34] In April 1995, Northwest Covenant Healthcare System changed its name to Northwest Covenant Medical Center and in 1998 to Saint Clare Hospital. Inc., its current name in March 1999. Saint Clare Health Services was created and became the sole member of Saint Clare Hospital, Inc.

[35] Exhibit I-8, Northwest Corporate By Laws. Article 3-Board of Trustees.

While the Northwest Corporate By-Law provides for a reduction of the number of Trustees, the reduction is to be taken equally from the members of the boards of the Provider (Dover) and St Clare. The Northwest Corporate By-Laws also provide for two physician members on the Board, one from the Provider's medical staff, and the other from St Clare.

In addition, the new consolidated entity had significant representation from the management team of Dover. As reflected in the Agreement to Consolidate, the President and CEO of Dover became the Executive Vice-President and CEO of the new entity. That is, there was the equal appointment of Officers between the two providers at the new entity.[36] While the Sisters did comprise the sole member of the new entity, the Northwest Corporate By-Laws provided that certain significant actions taken by the corporate member required a super majority. A super majority vote is defined as a majority vote of its Board of Trustees and a majority vote of the Dover Trustees and a majority vote of the St. Clare's Trustees who serve on the corporate members Board of Trustees.[37] In addition, the Northwest By-Laws provide certain assurances from the corporate member (and its sole corporate member), that it will not exercise any of the sole member's reserved powers in a manner which would undermine or be contrary to the Plan of Consolidation creating the corporation.[38] Finally, the provisions for the dissolution recognize the separate interests of the Provider, Dover, and St Clare in allocating the proceeds of any corporate dissolution in proportion to their respective balance sheet at the time of the consolidation.[39]

The Administrator finds that the Provider's post-consolidation control was comparable to the pre-consolidation control. These facts evidence a continuity of control between the Provider hospital and the post-consolidation corporation. In addition, there was also a continuity of business enterprise and purpose between the Provider and the post-consolidation entity.[40] Accordingly, the Administrator

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[36] Exhibit I-9, Agreement to Consolidate, Article IV.

[37] Exhibit I-8, Northwest By Laws, Article 2.3.

[38] Exhibit I-8, Northwest By Laws, Sections 2.4 and 2.6. The Agreement to Consolidate specifically provided for the super majority "to accommodate the separate interests" of Dover and St Clare. Exhibit I-7 at p.2. In addition, the Exhibit P-33 shows that Dover had an approximately 30 percent representation on the sole members board The sole member's corporation by laws are not included in the record.

[39] Exhibit 1-9, Agreement to Consolidate, Section 1.06(g).

[40] See, e.g., Exhibit P-13. By-Laws of Dover General Hospital and Medical Center. Article I-Organization, Section A. Name and Purpose and Exhibit I-8. Northwest By-Laws: Introduction and Section 1.5. Purposes.

finds that the record contains compelling evidence on the relatedness of the Provider and the consolidated corporation. The transferor of the depreciable assets was, in essence, also the transferee of the depreciable assets. 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.

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 Provider that can be recognized by Medicare under §1861(v)(1)(a) of the Act.[41]

The Administrator finds that 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 how the transaction is titled, when there is a continuity of interest or control between the constituent corporations and the new corporation. That is, evidence of a continuity of interest or control, is evidence that the entity has but recast its interest in another form, as in a reorganization, and no actual loss has been incurred. The reasonable cost rules must be interpreted consistent with this economic reality.

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 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

[41] 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.

depreciable asset rules set forth at paragraph (f) and thus must be interpreted consistent with those provisions.[42]

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 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

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[42] 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 (1) 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.")

> 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, 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. The record does not show that the Provider sought out other purchasers, or tried to quantify the value of its assets in the open market. Instead, other considerations unique to not-for-profit entities were at issue in the consolidation.[43]

Further, the consideration received for the depreciable assets supports a finding that the transaction did not constitute a bona fide sale. At the time of the consolidation, based on the Provider's September 30, 1994 audited financial statement, the Provider's current, non-current and monetary and depreciable assets had a total value of $101,372,740.[44] The fixed assets had a fair market

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[43] Provider Exhibit P-2. Joint Task Force Resolution-September 29, 1993. For example the joint task force met and "evaluated information concerning the hospitals, industry trends, market environment, payer/reimbursement systems, new or expanded services, community needs and potential savings and other relevant input." The joint task force concluded that it would be in the best interest of the community served by Dover and St Clare's to consolidate the two institutions. The matter of consideration was not raised.

[44] See Dover General Hospital and Medical Center -Balance Sheets: Source September 30, 1995 Financial Statements.(Unnumbered Exhibit.)

value of $51,424,000[45] and a net book value of $50,008,114. These assets were transferred in exchange for $66,975,372 in assumed debt. (The financial statement showed additional debt related trustees funds that decreased the net liabilities assumed to $61,023,723 as the "purchase price".) The assets were sold for approximately 60 percent of their fair market value. The Administrator finds that the transfer of the assets of a book value of approximately $100 million for approximately $60 million dollars indicates the lack of a bona fide sale or transaction.[46]

Finally, as a loss cannot be allowed in this case, the Administrator does not reach the issue of how to calculate the loss. However, 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.[47] The Administrator concludes that this further supports a finding that no loss is to be calculated under the facts of this case. 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.[48] There is no explicit regulatory

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[45] The Provider also submitted an appraisal conducted after the transaction date in June 1997. The appraisal shows the Provider's property plant and equipment and intangible assets (medical records, assembled work force, etc.) valued at $66,120,000. Exhibit P-11. As noted above, the land, buildings, and equipment had a fair market value of approximately $51 million. This amount was close to the net book value of the assets.

[46] Exhibit P-16 at p 7. The document entitled "Purchase Price Allocation" shows $110,117,091 in assets with $49,630,000 attributable to building, equipment, & land improvements. The purchase price of net liabilities assumed is listed at $61,023,0723. These figures show a wider discrepancy between the 'sale price' and the value of the assets.

[47] Exhibit P-11. In this document, the Provider allocates $27 million of the "sale price" to assets having a net book value of $48 million resulting in a loss of $22 million almost half of the book value. Although this itself shows a large disparity in the "sale price" and the book value, while not conceding any allocation method, to allocate on a dollar-to-dollar basis even more significantly increases the Medicare liability. The foregoing loss is based on the Provider allocating $2.3 million of the "sale price" to the $4 million in cash, resulting in a loss of $1.8 million for the cash asset.

[48] 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

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 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 consolidation."

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 [not-for-profit] 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 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….".

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: 11/12/04

/s/
Leslie V. Norwalk, Esq.
Deputy Administrator
Centers for Medicare & Medicaid Services