CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Robert F. Kennedy Medical Center **Provider** **vs.** **Blue Cross /Blue Shield Association/ United Government Services, LLC-CA** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 05/30/96** **Review of: PRRB Dec. No. 2005-D9 Dated: December 10, 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 § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The Intermediary submitted comments, requesting reversal of the Board's decision. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were also received from the Center for Medicare Management (CMM) requesting reversal of the Board's decision. No comments were received from the Provider. 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 adjustment disallowing the Provider's claimed loss on the disposal of assets due to a change of ownership was proper.[1]

[1] Section 4404 of the Balance 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 sale or scrapping. Conforming modifications to the applicable regulation made December 1, 1997 the effective date for implementing the new rule.

The Board held that the Intermediary's adjustment disallowing the loss on the disposal of assets due to the merger was improper. The Board held that the merger resulted in a loss under 42 C.F. R. § 413.134(f). The Board rejected the Intermediary's assertion that the Provider and CHW Southern California were related parties prior to the merger. The Board concluded that the plain language of the regulation barred application of the related party principle to post-merger relationships. The Board concluded that the regulation only required that the parties prior to the merger not be related. Furthermore, the Secretary's interpretive guidelines found at HCFA Pub. 1304 § 4502.3, which stated in part: "Medicare program policy permits a revaluation of assets acquired in a statutory merger between unrelated parties, when the surviving corporation is a provider" only helped to support the Board's determination.

The Board also rejected the Intermediary's argument that the transaction failed the traditional test of "bona fide" and at "arm's length." The Board noted that the Provider determined on its own initiative, absent of CHW Southern California involvement, to seek an affiliation with a larger health system. In fact, the record showed that the Provider requested and discussed its sale with several health systems interested in merging. Therefore, the Board held that the transaction was "bon fide."

The Board also rejected the Intermediary's argument that the merger did not give rise to a gain or loss because it was accounted for as a pooling of interest on the financial statements of CHW Southern California (CHW-SW) following the merger. The Board concluded that the treatment afforded a transaction for financial statement and Internal Revenue Services purposes did not control the treatment required for Medicare purposes. Accordingly, when a gain or loss is recognized for Medicare purposes the regulation at 42 C.F.R. § 413.134(l) is controlling.

Finally, the Board disagreed with the Provider's methodology of allocating the consideration received over the Provider's various assets to determine the loss. The Board stated that it preferred the proportionate value method to allocate cost to various assets values in existence at the time of the merger. Accordingly, the Board required the Provide and the Intermediary to recalculate the loss resulting from the merger using the proportionate method for all assets as required by 42 C.F.R. § 413.134(f) (2) (iv).

SUMMARY OF COMMENTS

Intermediary Comments

The Intermediary submitted comments requesting that the Administrator reverse the Board's decision. The Intermediary argued that the Board's decision looks at 42 C.F.R. § 413.134(l) in a vacuum and ignores the purpose of the regulation. In this case, the Intermediary stated that there was no semblance of a "bona fide" sale. The Intermediary argued that there was no loss suffered, and there was no underpayment of depreciation in prior periods.

CMM Comments

CMM commented requesting that the Administrator reverse the Board's decision. CMM argued that the Provider failed to show that there was a *bona fide* sale of its depreciable assets. CMM argued that the transaction was not a *bona fide* sale due to the great discrepancy between the assets and the consideration properly allocated to them. The Provider transferred current assets valued at approximately $29 million and fixed assets valued at $21 million in exchange for approximately $30.5 million. CMM stated that the Provider essentially gave away its depreciable assets. In addition, as the same legal issue was presented in Cushing/Goddard, AHS 96 Related Organization Group Appeal and Meridian Hospitals Corporation Group Appeal, CMM attached and incorporated by reference those comments in those cases. Furthermore, the fact that the Provider did not secure an appraisal, nor was there any documentation in the record as to why the parties thought the assumption of debt was fair consideration is an indication that the Provider was not concerned with receiving reasonable consideration for its depreciable assets. CMM stated that the rules on claiming a loss on sale, as are the rules on reasonable cost, are intended to award reimbursement to providers for the costs actually incurred. They are not intended to grant reimbursement to providers that, through some special consideration of their own, decide to sell their assets for less than fair market value.

DISCUSSION

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

I. Medicare Law and Policy -- Reasonable Costs.

Section 1861(v)(1)(A) of the Social Security Act establishes that Medicare pays for the reasonable cost of furnishing covered services to program beneficiaries, subject to certain limitations. This section of the Act also defines reasonable cost as "the cost actually incurred, excluding there from any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The Act further authorizes the Secretary to promulgate regulations establishing the methods to be used and the items to be included in determining such costs. Consistent with the statute, the regulation at 42 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[2] 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[3] 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

[2] Pub. Law 98-21.

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

system for the capital-related costs of PPS hospitals for cost reporting periods beginning in fiscal year (FY) 1992.

1. Depreciation.

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

> Medicare reimburses providers for the direct and indirect costs necessary to the provision of patient care, including the cost of using assets for inpatient care. Thus, depreciation of those assets has always been an allowable cost under Medicare. The allowance is computed on the depreciable basis and estimated useful life of the assets. When an asset is disposed of, no further depreciation may be taken on it. However, if a gain or loss is realized from the disposition, reimbursement for depreciation must be adjusted so that Medicare pays the actual cost the provider incurred in using the asset for patient care.[4]

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.

[4] 44 Fed. Reg. 3980 (Jan 19, 1979).

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 computation and treatment of gains and losses in determining reasonable costs. [5]

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. [6] (Emphasis added.)

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

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[5] 41 Fed. Reg. 35197 (August 20,1976) "Principles of Reimbursement for Provider Costs: Depreciation: Allowance for the Depreciation Based on Asset Costs." (Proposed rule.)

[6] 44 Fed. Reg. 3980. (1979) "Principles of Reimbursement for Provider Costs."(Final rule.)

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

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

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

With respect to paragraph (f) (2) and the *bona fide* sale of a depreciable asset, 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. [7]

With respect to assets sold for lump sum, paragraph (f) (2) (iv) specifies:

> If a provider sells more than one asset for a lump sum sales price, the gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sales price among all the assets sold, in accordance with the fair market value of each asset as it was used by the provider at the time of sale. If the buyer and seller cannot agree on an allocation of the sales price, or if they do agree but there is

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

> insufficient documentation of the current fair market value of each asset, the intermediary for the selling provider will require an appraisal by an independent appraisal expert to establish the fair market value of each asset and will make an allocation of the sale price in accordance with the appraisal.

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[8] 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 losses is generally only of interest to the prior owner,[9] 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(l)[10] were promulgated to address longstanding Medicare policy regarding

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[8] 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.

[9] 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.

[10] (1995) Originally codified at 42 CFR §405.415(l).

depreciable assets exchanged for capital stock, statutory mergers and consolidation. Concerning the valuation of assets, the regulation states that:

> (l) *Transactions involving a provider's capital stock—*
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> (2) *Statutory merger*. A statutory merger is a combination of two or more corporations under the corporation laws of the State, with one of the corporations surviving. The surviving corporation acquires the assets and liabilities of the merged corporations(s) by operation of State law. The effect of a statutory merger upon Medicare reimbursement is as follow:
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> (i) *Statutory merger between unrelated parties*. If the statutory merge is between two or more corporations that are unrelated (as specified in §413.17), the assets of the merged corporation(s) acquired by the surviving corporation may be revalued in accordance with paragraph (g) of this section. If the merged corporation was a provider before the merger, then it is subject to the provisions of paragraphs (d) (3) and (f) of this section concerning recovery of accelerated depreciation and the realization of gains and losses. The basis of the assets owned by the surviving corporation are unaffected by the transaction. An example of this type of transaction is one in which Corporation A, a nonprovider, and Corporation B, the provider, are combined by a statutory merger, with Corporation A being the surviving corporation. In such a case the assets of Corporation B acquired by Corporation A may be revalued in accordance with paragraph (g) of this section.
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> (ii) *Statutory merger between related parties*. If the statutory merger is between two or more related corporations (as specified in §413.17), no revaluation of assets is permitted for those assets acquired by the surviving corporation. An example of this type of transaction is one in which Corporation A purchase the capital stock of Corporation B, the provider. Immediately after the acquisition, of the capital stock of Corporation B, there is a statutory merger of Corporation B and Corporation

> A, with Corporation A being the surviving corporation. Under these circumstances, at the time of the merger the transaction is one between related parties and is not a basis for revaluation of the provider's assets.

B. Related Organizations

The regulation at 42 C.F.R. § 413.134 references the related organization rules at 42 C.F.R. § 413.17. The regulations at 42 C.F.R. § 413.17, states, in pertinent part:

> (b) *Definitions. (1) Related to the provider*. Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.
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> (3) *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.
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> (4) *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).[11]

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

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

The related party organization was further explained in HCFA Ruling 80-4, which adopted the Eighth Circuit Court of Appeals' decision in Medical Center of Independence v. Harris, (CCH) Para. 30,656 (8th Cir. 1980).[12] 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

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

[12] In Medical Center of Independence, supra, the court held that a medical center and a management corporation from which it leased and operated a hospital facility were related organizations within the meaning of § 413.17, where the management corporation had purchased the assets of the hospital and had entered into a 15 year lease agreement with the hospital, with a management agreement to run concurrently with the lease, and where six employees of the management corporation were elected as directors of the hospital, and two were elected as hospital officers. The court upheld the District Court's finding that the management corporation had the power, directly or indirectly, significantly to influence or direct the actions or policy of the hospital, and rejected a contention that potential influence, in the absence of a past and present exercise of influence, is insufficient to warrant a finding of control. The court stated that while the absence of any prior relationship between the parties is relevant to the issue of control, it should not automatically lead to the conclusion that the related party principle does not apply.

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 C.F.R.§ 413.134(l) to non-profit providers with respect to the related party rules and the rules on the disposal of depreciable assets, CMS issued Program Memorandum (PM) A-00-76, dated October 19, 2000. This PM applies the foregoing regulations to the situation of non-profit corporations. In particular, this PM noted that non-profits differ in significant ways from for–profit organizations. Non-profit organizations typically do not have equity interests (i.e. shareholders, partners), exist for reasons other then to provide goods and services for a profit, and may obtain significant resources from donors who do not expect to receive monetary repayment of or return on the resources they provide. These differences, among others, cause non-profit organizations to associate or affiliate through mergers or consolidations for reasons that may differ from the traditional for-profit merger or consolidations. In contrast, the regulations at 42 C.F.R. § 413.134(l) were written to address only for-profit mergers and consolidations.

The PM also noted that, unlike for-profit mergers or consolidations, which often involve a dispatching of the former governing body and/or management team, many non-profit mergers and consolidations involve the continuation, in whole or part, of the former governing board and/or management team. Thus, in applying the related organization principles of 42 C.F.R. § 413.17, CMS stated that consideration must be given to whether the composition of the new board of directors, or other governing body and/or management team include significant representation from the previous board or management team. If that is the case, no real change of control of the assets has occurred and no gain and loss may be recognized as a result of the transaction. This PM recognized that, inter alia, certain relationships formed as a result of the merger or 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 C.F.R. § 413.17 and the PRM at Chapter 10. Important considerations in this regard include that the determination of common control is subjective; each situation stands on its own merits and unique facts; a finding of common control does not require 50 percent or more representation; there is no need to look behind the numbers to see if control is actually being exercised, rather the mere potential to control is sufficient.

In addition, 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 42 C.F.R § 413.134(l) and as defined in the PRM at § 104.24. The PM stated that the regulation at 42 C.F.R. § 413.134(l) does not permit a gain or loss resulting from the combining of multiple entities' assets and liabilities without regard to whether a bona fide sale occurred. The PM stressed that a bona fide sale requires an arm's length business transaction between a willing and well-informed buyer and seller. This also requires the analysis of the comparison of the sales price with the fair market value of the assets acquired as reasonable consideration is a required element of a bona fide sale.

Notably, the Administrator finds that the requirement that the term "between related organizations" includes an examination of the relationship before and after a transaction of assets under 42 C.F.R. § 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.[13] 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.[14] 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 merging of two or more entities. For example:

> Corporation A and Corporation B, both non-profit providers, are combined by statutory merger with Corporation A surviving. Corporations A and B were unrelated prior to the transaction, each being controlled by its respective Board of ten Directors. After the merger, Corporation A's new ten member Board of Directors includes five individuals that served on Corporation B's pre-merger board. Thus, Corporation A's new Board of Directors includes a significant number of individual from both of the former entities' boards. Because no significant change of control of the assets of former Corporation B has occurred, the transaction as between Corporation A and Corporation B is deemed to be between related parties and no gain or loss will be recognized as a result of the transaction. Hence, Medicare reasonably examines the relationship between the merging corporations and the surviving corporation and recipient of the Medicare depreciable assets to determine whether the transfer involved a related party transaction.[15]

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

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[13] 42 Fed. Reg. 45897 (1977).

[14] 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.)

[15] Program Memorandum A-00-76 at 3.

transaction is to determine the provider structure both before and after the transaction and to determine the type of transaction which occurred because Medicare 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. Section 4502.1, list the various types of provider organizational structures and included as one possible type of provider organization are Corporations.

In defining a Corporation, § 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. 6, describes a statutory merger as the combination of two or more corporations pursuant to the laws of the state involved, with one of the corporations surviving the transaction. Medicare program policy permits a revaluation of assets acquired in a statutory merger between unrelated parties, when the surviving corporation is a provider. 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 re-organization, CMS examines, inter alia, the parties before and after the transaction in determining that the transfer of assets involved a related party transaction.

Similarly, § 4502.11 of the Manual explains regarding transfers of sponsorship, that: "A transfer of sponsorship or membership of a nonprofit, nonstick corporation is not, in itself , a CHOW for Medicare reimbursement purposes. It is similar to the transfer of stock in a proprietary corporation. The ownership of corporation assets is vested in the corporation itself, therefore a change in the membership or sponsorship of the corporation cannot be deemed a CHOW for purposes of the assets.

Section 4508.11 of the Intermediary Manual,[16] in addressing stock corporations states that, Medicare program policy places reliance on GAAP, as expressed in 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,[17] 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.

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 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 or Merge.

This policy of not recognizing a gain or loss when the transaction is between related parties, whether it constitutes a reorganization, consolidation or merger, 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

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[16] 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."

[17] 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).

Medicare policy is not bound by IRS policy, IRS policy often reflects rationale underlying the establishment of similar policies under Medicare.[18] 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.[19]

Under IRS rules, some mergers are considered statutory reorganizations and subject to the non-recognition of a gain or loss. The terms reorganization and merger 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.[20] For example, a merger where the predecessor corporation board continues significant control in the new corporation board is treated the same as 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 re-organization, 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

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[18] 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).

[19] 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 un-depreciated 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).

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

> interest and control accomplished [in this instance] by an exchange of stock for stock.[21] (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."[22] 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 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."[23]

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

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[21] 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).

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

[23] 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)).

> 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, consolidation or merger 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.

The Intermediary did not make a finding of whether the parties were related within the meaning of 42 CFR 413.17 and the record was not been well developed as to the composition of the entities before and after the merger. However, the following facts are evident.

Effective March 25, 1996, Kennedy Health Services Corporation[24] (KHS) (the parent corporation) and Robert F. Kennedy Medical Center (RFK) (Provider) entered into a merger agreement with St. Francis Medical Center (SFMC) and Catholic Healthcare West (CHW)[25] (the parent corporation) (also referred to as the CHW parties) whereby effective May 30, 1996, the RFK would merger into SFMC. Pursuant to the agreement, SFMC survived the statutory merger and changed its name to Catholic Healthcare West Southern California (CHW-SC).[26]

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[24] Provider's Exhibit P-7. KHS is also the sole corporate member of Robert F. Kennedy Foundation which engages in fund raising activities for the Provider and the communities it serves. KHS owned certain properties, specifically, a single family dwelling and a condominium interest in a medical office building.

[25] Id. CHW is sponsored by several different Catholic religious orders, and operates numerous hospitals throughout California and elsewhere.

[26] Id. at p. 5.

As a result of the merger, CHW-SC became the new corporate owner of the RFK's assets and liabilities. Actual legal ownership of the RFK's assets was "grant deeded" to CHW-SC on May 30, 1996. [27]

Pertinent parts of the merger agreement are as follows: Section 2.3 sets forth the initial Board of Directors. Section 2.3.1 states that the initial board of directors would be "Those individuals whose names appear on Attachment 2.3.1 to this agreement …shall be the members of the board of directors of [CHW-SC]… as of the closing date.…"

Section 2.3.2 states regarding "Additional Voting Member of the Board" that "On the earlier to occur of (a) January 1, 1997, or (b) the closing of the transaction pursuant to which one or more additional hospitals become part of [CHW-SC], either by merger, or pursuant to a parent/subsidiary relationship, the number of directors of [CHW-SC] shall be increased to permit KHS to nominate one additional director to be appointed by CHW to serve a term which will expire June 30, 1998, concurrent with the terms of the directors listed on Attachment 2.3.1. Further the person to be nominated by KHS pursuant to this section 2.3.2 shall be permitted to attend all meetings of the Board of Directors of [CHW-SC] that are held prior to his appointment to the Board as a voting member, and the name of such nominee is included on Attachment 2.3.1 as a nonvoting member of the Board."

In addition, that paragraph provided that if a stand alone hospital with the like or lesser net equity than the RFK became apart of CHW-SC through either consolidation, purchase, or merger, prior to June 30, 1998, and given the right to nominate more then two directors to the board of Directors of CHW-SC, KHS will have the right to nominate an additional director so that the KHS nominees on the board of Directors are equal in number to the nominees of the newly affiliated corporation.[28]

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[27] Provider's Exhibit P-9.

[28] Consistent with the agreement, the record shows that immediately following the merger, one member of the RFK's former Board of Directors became a voting member of CHW-SC 16 member Board of Directors. A second former Board member of the RFK became a non-voting board member of CHW-SC as noted in the merger agreement to be converted to a voting member as allowed under the agreement. Provider Exhibit 48 and 49 show the Board of director composition for KHS and RFK. Provider Exhibit P-7-A-4 (CHW-SC's initial board of directors..)

Section 2.5.4 of the agreement provides that the former RFK parent, KHS continued to be stand alone entity (i.e., not affiliated with CHW or CHW-SC) following the closing date "for the purposes stated in Section 3.2…"

Pursuant to section 2.6.1, all of the RFK's assets and properties transferred to CHW-SC on May 30, 1996. Section 2.6.2 of the agreement also provided that the RFK and CHW-SC would engage a valuation firm to conduct an appraisal of the assets of the Provider as of the closing date of this transaction and that any gain or loss related to the assets of the Provider would be realized by CHW-SC.

Section 3.1.5.1 provides certain appeal rights to KHS were a decision to be made to terminate RFK's acute care license during the transaction period.

Section 3.2 addresses the "Functions of KHS" (the former parent) and provides that during the transition period, KHS shall have the following functions and perform the following services: "Charitable activities in support of RFK and the health care needs of the communities RFK has traditionally served"; "monitor compliance by the CHW parties with the terms of the agreement, including the provision of section 3.1"; "recommend nominees to serve on the Board of Directors and committees of CHW Southern California in accordance with the CHW Southern California Bylaws, and on the Board of Directors and committees of the RFK Foundation in accordance with the RFK Foundation bylaws"; and "serve in an advisory capacity to the RFK Foundation and continue to serve as the sole shareholder of Kennedy Ventures a California Corporation."

Section 3.3 provides that effective on the closing date, KHS shall sell and transfer to RFK, free and clear of all title, defects or objections not acceptable to CHW, real property, together with any and all rights and options to acquire real property, all as described in exchange for the sum of two million dollars and the assumption of all debt outstanding on the real property on the closing date.

Section 4.1.1 provided that the initial site administrator of RFK would be Patricia Cunningham (the prior president and chief financial executive of RFK). Each hospital was to maintain separate medical staff. Section 4.1.2 provided that day-to-day management of each hospital would be the responsibility of the specific hospital.[29]

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[29] The merger agreement does not address the disposition of assets were the corporation to dissolve. However, a letter, dated May 28, 1996 to RFK regarding the sponsorship of the hospital by the Daughters of Charity noted that while RFK would operate as a catholic hospital, if the RFK facilities were ever liquidated, "the congregation will be in the position to recognize the contribution of the community to RFK without the strictures imposed upon church property." Provider Exhibit-74.

Concurrent with that agreement, the CHW parties (St. Francis Medical Center, Catholic Heathcare West (CHW) and St. Vincent Medical Center, (a nonprofit corporation of which CHW was the sole member) entered into an agreement of co-sponsorship[30] and merger dated May 30, 1996 with the "SCH parties" consisting of the Sisters of Charity of the Incarnate Word, Houston (SCH) (a Texas nonprofit corporation), St Bernadine Medical Center and St. Mary Medical Center (two nonprofit corporations of which SCH was the sole member); and the Congregation of the Sisters of Charity of the Incarnate Word Houston Texas (CCVI)(the sponsor of SCH, SBMC, SMMC).[31] St Francis Medical Center (or SFMC) was the surviving corporation (renamed CHW-SC) as a result of that merger.

The Administrator finds that, as the issue under appeal involves the recognition of depreciation loss on the transfer of assets from a merger between non-profit entities, he cannot limit his review to 42 C.F.R. § 413.134(l). Paragraph (l) was drafted specifically to address the revaluation of assets for proprietary corporations that merger or consolidate, while paragraph (f) specifically addresses circumstances under which a gain or loss will be recognized. Paragraph (l) did not modify or limit the general related party rules at 42 C.F.R. § 413.17 and does not address or modify the criteria for the recognition of gains or losses at paragraph 42 C.F.R. 413.134(f). Instead, the Secretary explicitly stated that this provision was being promulgated consistent with both the related party rules and the disposal of depreciable asset rules set forth at paragraph (f) and thus must be interpreted consistent with those provisions.[32]

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[30] A sponsor was defined as a religious congregation community province, canonical institution or other organization of religious persons recognized by the Roman Catholic Church that cares out health care ministry.

[31] Provider Exhibit P-8. In the end, five hospitals were being merged as part of CHW Southwest. See e.g. Provider Exhibit-51 (Letter dated May 6, 1996 to the Office of the Attorney General regarding merger amongst St. Bernardine Medical Center, St. Mary Medical Center, St, Francis Medical Center, St, Vincent Medical Center and RFK.)

[32] 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

Applying the law to the facts developed in this case, suggests that the Provider was related to the surviving entity. The Provider's representation on the surviving corporation's board of directors appeared to be proportional to the equity value of the Provider's assets showing a continuity of interest in the new entity proportional to the Provider's net equity.[33] In addition, evidence shows that the Provider had an expectation that the transaction was but a continuation of it in another form as a Catholic hospital.[34] The mission of the new entity was similar to the Provider's community health care mission.[35] There appeared to be a continuation of the

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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 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.")

[33] This presumption is based on the fact that RFK was to be assured the same representation on the Board of CHW- SC as any stand alone hospital of "equal or less net equity" worth that would be added to the corporation. In addition, Provider Exhibit 6 at 20 shows that the other hospitals in the merger were, in all, significantly larger than RFK with bed sizes of 385 up to 551 as compared to RFK's bed size of 274. See also Intermediary Exhibit 6 CHW-SC Combined Financial Statements as of June 30,1996, 1995, 1995 showing comparative net assets of hospitals.

[34] See, e.g , Provider Exhibit 6.. When exploring becoming a Catholic health care institution, the report noted that the Provider already had a close relationship with a large Catholic church that provided a significant source of patients; it had previously reviewed the potential market impact of a regional Catholic network; much of the medical staff were already members of other neighboring Catholic hospitals; OB/GYN services were not currently provided by the Provider; becoming a Catholic facility was value added in the market area based on the demographics and would be of significant importance in attracting the Hispanic population; there was congruity of mission, values and culture; and the public perception of the quality of Catholic Hospitals supported the decision to adopt the Moral and Ethical Directives for Catholic Healthcare Institutions.

[35] See Intermediary Exhibit 5 at 2 (Board Minutes concerning member of the Daughters of Charity (group sponsoring RFK's health care ministry) statements to RFK Board that "the Daughters' ministry is designed to serve the health care needs of the poor and therefore should be viewed as largely consistent with the charitable purposes of the medical center.") See also Provider Exhibit 6 at p 5 that Provider

Provider's former senior management team.[36] Moreover, the Provider's former parent corporation, KHS survived the merger in the end being related to the surviving entity and continuing to have the authority to nominate Board members and work on behalf of the RFK (the former Provider), showing a continuity of interest and business enterprise of RFK.

The Administrator finds that the rationale for finding that this entire transaction constitutes a related party transaction under Medicare policy is supported by the record. 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 Provider's same interests, as the merged corporation, have been but recast in a different form only and, thus, a loss has not actually been incurred by the constituent corporations that can be recognized by Medicare under §1861(v)(1)(a) of the Act.

The Administrator finds 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. That is, evidence of a continuity of interest or control, is evidence that the entity has but recast its interest in another form and no actual loss has been incurred. Reasonable costs rules must be interpreted consistent with this economic reality. [37]

However, more importantly, the Administrator finds that the disposal of asset rules of paragraph (f) are properly applied in the event of a merger as in this case. This means that in order for a loss to be recognized, a transaction resulting in the transfer

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was seeking. affiliation or merger for, inter alia "continuance of our mission to serve the community" with a criteria for selection of a partner "to continue to service its community." Id.. at 6. Provider Exhibit 6 at 14 states the CHW mission "is to improve the health of the communities we serve and to treat each patient with dignity and compassion."

[36] See Provider Exhibit 7.A. Merger Agreement section 4.1.1. See also Intermediary Exhibit-6 at 12 (Board Resolutions prior to merger discussing settlement agreements with the three executive officers "designed in part to provide incentive for the executives to continue to work at RFK.")

[37] Notably, the merger was treated as a pooling of interest. Once again, while Medicare rules are not bound by IRS rules, there are some shared concepts on when a loss will be recognized. In addition, 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.

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" as required under paragraph (f)(2) and the Provider failed to met any other criteria under which a loss on the disposal of assets will be recognized at §413.134(f).

As the PRM explains, "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. As also set forth in PM A-00-76, reasonable consideration is a required element of a *bona fide* sale. Therefore, a comparison of the sale price with the fair market value (FMV) of the assets is required.[38] A large disparity exists between the sale price (consideration) and the FMV indicates the lack of a *bona fide* sale. Moreover, the Administrator finds that in analyzing whether a *bona fide* sale has occurred, a review of the allocation of the sales price among the assets sold is appropriate. Examples of transactions that raise the issue a bona fide sale are set forth in PM A-00-76:

> In some situations, the "sales price of the assets may be barely in excess of, or less than, the market value of the current assets sold, leaving a minimal, or no, part of the sales price to be allocated to the fixed (including the depreciable) assets. In such a circumstance, effectively the current assets have been sold, and the fixed assets have been given over at minimal or no cost. If a minimal or no portion of the sales price is allocated to the fixed (including the depreciable) assets a *bona fide* sale of those assets has not occurred.

PM A-00-76 further states that:

> Non-monetary consideration, such as a seller's concession from a buyer that the buyer must continue to provide care for a period of time or to provide care to the indigent, may not be taken into account in evaluating the reasonableness of the overall consideration (even where such elements may be quantified in dollar terms). These factors are more akin to goodwill than to consideration.

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

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[38] 42 CFR § 413.134(b)(2) defines fair market value (FMV) as the price that *bona fide* sales are consummated for like type, quality, and quantity in a particular market at the time of acquisition.

transaction. In particular, the Administrator notes that the Provider was more concerned with community considerations and the future of the Provider in the community rather than obtaining fair market value for its assets. The Report "Pursuit of a Partner"[39] stated that the Provider must seek affiliation or merger with a large integrated healthcare delivery system for following reasons:

- Continuance of our mission to serve the community;
- Access to Capital at reduced rates for debt re-financing, proposed OB/Renovation Construction Project, technology acquisition, and expansion of services..
- Access to managed care contract as a regional organization of hospitals,
- clinics and other providers of care.
- Access to established integration models for physicians.
- Survivability as an acute care hospital in a marketplace dominated by hospital mergers, affiliations, and consolidations.
- Access to corporate system services which will result in a lower cost of delivery of care.[40]

In addition, the Provider set forth criteria for a selection of a "partner." The following criteria was established for the selection of a potential affiliation partner:

- RFKMC to continue to serve its community.
- Similar Culture/Values.
- Capital resources.
- Preference for a not-for profit partner and system.
- Strong in managed care.
- Future-focused vision and Strategic Plan.
- Management Expertise.
- Southern California presence to increase leverage.
- Strategy for Physician Collaboration.[41]

In evaluating the various possible partners, using the foregoing criteria, the issue of consideration was never addressed.[42] In fact, the merger was structured to maximize

[39] Provider Exhibit 6.
[40]Provider Exhibit 6 at 5.
[41] Provider Exhibit 6 at 6.
[42] Provider Exhibit 41 at 7-8.

Medicare depreciation reimbursement,[43] reimbursement that was to be for the benefit of the surviving entity.

In addition, the record shows that the Provider transferred "current assets" valued at approximately $29 million and "fixed assets" valued at $21 million in exchanged for approximately $30.5 million in net liabilities. This resulted in assets with a net book value of $50 million being transferred for a total of $30.5 million in "consideration." The Administrator finds that the large disparity of approximately $20 million, between the asset values and the consideration received, reflects the lack of arm's length bargaining, and thus the lack of a *bona fide* sale.[44]

In the Administrator's view, the "sale price" on its face, does not support a finding that the transaction was an arm's length transaction. Moreover, the fact that the parties did not secure an appraisal prior to the transaction is an indication that the Provider was not concerned with receiving reasonable consideration for its depreciable assets. There is no documentation in the record that the parties concluded that the assumption of debt was fair consideration for the Provider's assets.[45]

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[43] See Intermediary Exhibit 5 at 5. ("Mr. Schuchard next reviewed the significant items relating to the merger. He indicated that four separate hospital corporations …will merge into the surviving corporation…. Mr. Schuchard explained that the merger of the entities is designed to attempt to result in certain reimbursement with respect to the hospital's participation in the Medicare program. Based on an evaluation of such issues, the Medical Center's management and CHW agreed that St. Francis would be the surviving corporation and will change its name to CHW-SC in connection with the merger.")

[44] In addition, there was some confusion in the treatment of the alleged $2 million dollar "purchase" of assets valued for less then one million by RFK from its related party RHS See CMM comment n. 1; Provider Exhibit-11 and Revised Provider Exhibit- 11(shows elimination of $2 million in cash assets and also "MOB cash" as part of total consideration paid.) In addition, this transaction occurred between parties that were related to each other before the merger, with the parent corporation KHS (with its supposed $2 million in hand) surviving the merger, yet now sharing the same co-sponsor as the surviving entity and same sponsor as RFK.

[45] The record also does not show that the parties were engaged in arms length bargaining, reflective of a bona fide sale of the assets, over the potential Medicare loss on sale claim. The record instead shows that the Provider was in fact cooperative in agreeing to the structure of the new entity to allow for such reimbursement. Intermediary Exhibit 5 at 5.

In fact, if the Provider's methodology is applied it means that the Provider transferred the depreciable assets for no consideration.[46] Without conceding this loss methodology, to find a bona fide sale there is a *logical* inconsistency which must be forced upon this transaction. That is, to find that any consideration was paid for the depreciable assets, a less than dollar-to-dollar allocation must be made to the monetary assets. When a dollar-to-dollar allocation is made to the current and monetary assets, the Provider in this case in fact disposed of the depreciable property for no consideration.

In conclusion, the Administrator finds that this is not reasonable consideration required of an arms length transaction and bona fide sale. Thus, the transaction fails to meet the criteria required under 42 CFR§413.134(f) for a loss on the disposal of assets to 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, the issue of calculating a loss does point out certain anomalous results of finding that a loss is to be calculated in a 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 these facts of this case.

[46] See Original Provider Exhibit 11 showing allocation of no consideration for the depreciable assets. The depreciable assets had an approximate net book value of $11.9 million. Under section 4505.12 a donation is considered donated when it is acquired without the payment in the form of cash, property or services-including the assumption of liabilities. When a provider is donated there is no gain/loss allowed to the donor.

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: 2/10/05

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