CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Whidden Memorial Hospital	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: 07/31/96, 09/30/96, 09/30/97 and 09/30/98**
Provider	
vs.	
Blue Cross Blue Shield Association	**Review of: PRRB Dec. No. 2009-D34 Dated: July 28, 2009**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the Center for Medicare Management ("CMM") and the Intermediary requesting reversal of the Board's decision in both issues. Comments were also received from the Provider requesting that the Administrator affirm the Board's decision in both issues. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE NO. 1 AND BOARD'S DECISION

Issue No. 1 is whether the Intermediary's audit adjustments disallowing the entire loss on the disposition of assets claimed by the Provider, when the Provider corporation merged with another provider corporation, were proper.

The Board held that the Intermediary improperly denied the Provider's loss on merger. The Board stated that the loss as calculated by the Provider is accurate and remanded the issue to the Intermediary for proper reporting of the loss in the FYE July 31, 1996 cost report.

The Board also held that the Intermediary's adjustment disallowing the Provider's claimed loss resulting from a statutory merger was contrary to the regulatory requirements of 42 C.F.R. §413.134(1)(2)(i). The Board found that the Provider and Melrose-Wakefield Hospital, were unrelated parties as defined under the regulatory provisions of 42 C.F.R. §413.7 and 42 C.F.R. §413.134. The Board stated that a revaluation of the assets and a recognition of the loss incurred as a result of the merger is required under the plain meaning of 42 C.F.R. §413.134(1)(2)(i).

The Board rejected the Intermediary's assertion that an examination of the relationship of both the parties prior to, and after, the merger is appropriate. The Board concluded that the plain language of the regulation barred application of the related party principle to post-merger relationships. The Board stated that the regulation only required that the parties prior to the merger not be related. Finally, the Board stated that even if the related party concept was applied to the entities post-merger, the percentage of provider "members" who obtained positions on the surviving entity's board does not constitute sufficient control.

ISSUE NO. 1 COMMENTS

Intermediary Comments

The Intermediary commented requesting that the Administrator reverse the Board's decision. The Intermediary pointed out that the transaction failed to meet the standards of a *bona fide* sale. When merged, Melrose Wakefield simply received the Provider's assets and liabilities. There was no genuine "purchase price" and, after the merger, there were a significant number of overlapping officers and members of boards of directors. The Intermediary reaffirmed its positions and arguments raised in its Post Hearing Memorandum.

Provider Comments

The Provider commented requesting that the Administrator affirm the Board's decision to allow the Provider's loss on disposal of assets resulting from its statutory merger with Melrose Wakefield, but modify the Board's decision related to the computation of the loss.

The Provider stated that the plain language of the statutory merger regulation is unambiguous in requiring only an analysis of the parties' relationship prior to the merger. Therefore, since the parties stipulated that, before the merger the parties to

the merger were unrelated, the stipulation is in line with this requirement and the regulation is satisfied.

The Provider also stated that the Board properly concluded that even if the post-merger relationship of the parties were considered, the parties were still not related within the meaning of the Medicare regulations. The percentage of Provider board members who obtained positions on the surviving entity's board did not constitute sufficient control. However, the Provider requested modification of the Board's decision with respect to the computation of the amount of the loss.

CMM Comments

CMM commented requesting that the Administrator reverse the Board's decision. CMM stated that the Board's decision contains several errors. First, the Board incorrectly found that the Intermediary could only examine whether the parties to the merger were related prior to the merger transaction. Consequently, the Board improperly rejected the Intermediary's argument that there was a continuity of control that resulted in the parties to the merger being related. The related party doctrine is not so limited, but is instead a broad rule designed to prevent Medicare from recognizing costs in transactions where the parties have incentives to sell above (or in this case below) fair market value.

CMM stated that after the merger, former officers and board members of the Provider became trustees, officers or served on executive committees of the newly merged entity and held 30 percent of those positions of control or positions of responsibility with the new entity. The significant representation of the Provider had on both boards was sufficient justification for the Intermediary to disallow the claimed loss on sale under the related party doctrine.

Finally, CMM argued that the Board erred in finding that the recognition of gains or losses after a merger was not subject to the bona fide sale requirement of the regulation. While a merger between unrelated parties may result in the recognition of a gain or loss, it is not automatic. The Provider's assets greatly exceeded the purported value of the Provider's assets, leading CMM to conclude it was not a bona fide sale. Moreover, there were no negotiations for the full price or information about consideration paid in the merger documents, therefore this did not constitute a bona fide sale.

ISSUE NO. 2 AND BOARD'S DECISION

Issue No. 2 is whether the Intermediary properly denied the Provider's application for a new provider exemption from the Routine Service Cost Limits or RCLs for its hospital-based skilled nursing facility ("SNF").

The Board determined that the Intermediary improperly denied the Provider's new provider exemption from the routine cost limits for its hospital-based skilled nursing facility. The Board stated that the acquisition of bed rights alone, from an unrelated provider through the purchase of a certificate of need (CON) or other mechanism used to transfer bed rights, does not, in itself, constitute a change of ownership (CHOW), nor does it affect the "new" provider's right to an exemption. The Board found that the guidelines that impute ownership of an unrelated provider to a provider that purchases a DON or obtains bed rights through other mechanisms are inconsistent with the regulations.

The Provider meets the definition of a "new" provider as set forth in the regulation in that it is a licensed and Medicare-certified SNF that has operated as this type of provider for less than three years. The Board also stated that its finding that the Provider met the threshold test for entitlement to a new provider exemption should obviate the need to address whether the Provider qualified for an exemption under other criteria, however the Board also found that the previous owner of the bed rights, Care Well, did not operate as a SNF in the three years prior to the March 4, 1996 certification date.

ISSUE NO. 2 COMMENTS

Intermediary Comments

The Intermediary commented, requesting reversal of the Board's decision. The Intermediary argued that, since the record demonstrates that medical records of residents have been destroyed, a remand for consideration of additional evidence is unnecessary. There is no further evidence available regarding the level of care afforded by the previous provider, therefore, the Board's decision should be reversed.

Provider Comments

The Provider commented, requesting that the Administrator affirm the Board's decision. The Provider stated that the Board correctly ruled that the Provider's

closure of the Care Well Manor Nursing Home and its purchase of Care Well's operating rights, did not constitute a CHOW.

The Provider also stated that the Board properly ruled that Care Well did not operate as the equivalent of a SNF during the prior three years before the transfer of the license to the Provider. Therefore, the Board correctly rejected the Intermediary's argument that the Provider needed to demonstrate that Care Well furnished only custodial services to show that Care Well did not operate as the equivalent of a SNF. Finally, in the alternative, the Provider argued it met the criteria for a new provider exemption under the relocation exception.

CMM Comments

CMM commented requesting that the Administrator reverse the Board's decision granting the provider an exemption. The Provider acquired the license to operate Care Well, a Medicaid certified facility which was temporarily suspended pending completion of the construction incident to the relocation and reactivation of the twenty beds at the hospital based SNF and operation of the hospital based SNF.

CMM stated that the Board improperly found that the purchase of the "rights to operate" does not, in itself, constitute a change of ownership and does not affect the Provider's right to a new provider exemption. CMM argued that a CON is an asset used to render patient care and that a CON transfer constitutes a change of ownership transaction for purposes of determining whether the Provider qualifies for an exemption as a new provider. Further, CMM stated that the prior owner of the right to operate the beds in fact provided the equivalent of SNF level services as evident from statutory and regulatory requirements under Medicaid and the Minimum Data Set Resident Assessment Instrument and the Medical Assessment Management Questionnaire ("MMQ"). In particular, the data in the MMQ shows that 52 percent of the patient population received skilled nursing services. Thus, even under a district court holding of 51 percent, the prior owner of the beds was primarily engaged in the provision of skilled nursing and related services. CMM also noted that the Provider received significant reimbursement above the cost limit for the provision of atypical services. Finally, the Provider has not provided sufficient documentation to demonstrate it meets the criteria to receive a new provider exemption under the relocation provision.

ISSUE NO. 1 DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator

has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

I. Medicare Law and Policy -- Reasonable Costs.

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

A. Capital Related Costs.

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

Title VI of the Social Security Amendments of 1983[1] 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[2] 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] Pub. Law 98-21.

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

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.[3]

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 C.F.R. § 413.130 explains, inter alia, that:

> (a) *General rule*. Capital related costs … are limited to:

[3] 44 Fed. Reg. 3980 (Jan. 19, 1979).

> (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. [4]

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. [5] (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:

> (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

[4] 41 Fed. Reg. 35197 (August 20, 1976) "Principles of Reimbursement for Provider Costs: Depreciation: Allowance for the Depreciation Based on Asset Costs." (Proposed rule.)

[5] 44 Fed. Reg. 3980. (1979) "Principles of Reimbursement for Provider Costs."(Final rule.)

> 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. [6]

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 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.

---

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

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[7] 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,[8] the new owner in the same transaction is interested in the determination of when Medicare will allow the revaluation of depreciation for purposes of calculating the new owner's depreciation expense.

This latter issue, on the revaluation of assets, was the subject of significant litigation for the Medicare program regarding complex transaction and resulted in agency rulemaking on the subject. In response to litigation, the regulations at 42 C.F.R. §413.134(l)[9] were promulgated to address longstanding Medicare policy regarding depreciable assets exchanged for capital stock, statutory mergers and consolidation. Concerning the valuation of assets, the regulation states that:

(l) Transactions involving a provider's capital stock—

---

[7] 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.

[8] 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.

[9] (1995) Originally codified at 42 CFR §405.415(l).

****

(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:

(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.

(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.

The Administrator finds that, as the issue under appeal involves the recognition of depreciation losses on the transfers of assets from a merger between non-profit entities, he cannot limit his review to the specific merger requirements of 42 C.F.R. §412.134(l). Paragraph (l) was drafted specifically to address the revaluation of assets for proprietary corporations, 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 §413.17 and does not address or modify the criteria for recognizing gains or losses at paragraph §413.134(f). Instead, the Secretary explicitly stated that this provision was being promulgated consistent with both the related party rules and the disposal of depreciable asset rules set forth at paragraph (f).[10]

B. Related Organizations

[10] 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 C.F.R. 405.415, concerning the allowance for depreciation based on asset costs; 42 C.F.R. 405.427, concerning cost related organizations; and 42 CFR 405.626, concerning change of ownership. We continue to believe that our interpretation and application of these regulations are reasonable and consistent with our statutory mandate to determine the scope of the reasonable costs for Medicare providers." (Emphasis added.)); 42 Fed. Reg. 6912 ("Our intent is not to change existing Medicare policy, but merely to state explicitly in the Code of Federal Regulations that which has been stated in the past in less formal settings."); 42 Fed. Reg. 17486(1977)("The proposed revision of paragraph (l) of 405.415 is also consistent with paragraph (f). When a provider's assets are sold the transaction causes adjustments to the seller's health insurance program allowance for the depreciation based upon the gain or loss on the sale of the asset. Because a sale of corporate stock is not a sale of the corporate assets, the provisions of paragraph (f) of 405.415 are not applicable to the seller after such a transaction."); 44 Fed. Reg. 6913 ("Only if the assets are transferred by means of a bona fide transaction between unrelated parties would revaluation be proper.")

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.
>
> (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.
>
> (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:

---

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

> 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 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,

---

[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.

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.

---

[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.)

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. [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 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).

---

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

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.

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

---

[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).

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 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]

---

[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).

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 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

---

[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.")

[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).

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 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

---

[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)).

similarly does not find that the provider has incurred an actual cost for purposes of Medicare reimbursement under such facts.

ISSUE NO. 1 FINDING OF FACTS AND CONCLUSION OF LAW

This particular issue involves the Provider's claim for a loss on the disposal of assets as a result of a merger. Everett Cottage Hospital d/b/a Whidden Memorial Hospital (the "Provider, WMH or Whidden") is a non-profit, general acute care hospital located in Everett, Massachusetts. Effective August 1, 1996, the Provider consummated a statutory merger with another Massachusetts non-profit corporation named the Melrose-Wakefield Hospital Association (MWHA) which owned and operated a community hospital in Melrose, Massachusetts, known as Melrose-Wakefield Hospital. A corporation known as Melrose-Wakefield Healthcare Corporation performed charitable functions in support of the MWHA. At the time of the merger, this entity became the sole corporation parent of the merged entities and changed its name to Unicare Health System, Inc.

The Plan and Agreement of the merger provide for «Whidden Hospital» to be merged into MWHA. The purpose of the surviving corporation was: to establish and maintain health care facilities for the diagnosis, treatment and care of sick disabled infirmed persons who are in need of such services; provide, render, and to employ others to provide and render, medical surgical and other health related services in any manner permitted under State law; to carry on charitable, scientific or educational programs designed to promote and improve the general health and wealth of the community; in support of its charitable mission, to make donations, transfers of assets, financial guarantees and to provide other forms of aid and assistance to or for the benefit of this corporation or any of its corporate affiliates; in general to do any and all other acts and things necessary incidental or useful to the establishment and operation of an organization for the foregoing purposes and to do and engage in any and all other lawful activities which may be engaged in by the corporation organized under the State. Provider Exhibit P-10.

The Provider submitted a terminating cost report for the period ended July 31, 1996, on which it claimed a loss on statutory merger. Upon audit of the Provider's cost report, the Intermediary disallowed the entire loss claiming that the statutory merger did not meet the requirements of a bona fide sale. The disallowance of the loss was reflected in a Notice of Program Review ("NPR") dated September 21, 1998.

A. Bona Fide Sale & Reasonable Consideration

Applying the foregoing provisions to the facts of this case, the Administrator finds that the Provider is not entitled to a loss on the disposal of assets because the Provider failed to show that there was a bona fide sale of its depreciable assets. The Administrator finds that, the Board's proposal, that the commencement of a statutory merger between two unrelated parties does not require the application of the "bona fide" sale requirement is erroneous. The application of the bona fide sale criteria, under these facts, is consistent with the plain language of the controlling regulation and Medicare policy and that criteria ensure that the Medicare program is paying "reasonable costs."

As stated above, a bona fide sale contemplates an arm's length transaction, between unrelated parties for reasonable consideration, with each party acting in its own self interest. As outlined in PM A-00-76, in evaluating whether a bona fide sale has occurred with respect to a merger or consolidation between or among nonprofit entities, a comparison of the sale price with the fair market value of the assets acquired is also required. A large disparity between the sale price (consideration) and the fair market value of the assets sold indicates the lack of a bona fide sale.

In allowing the loss, the Board concluded that the Provider did seek monetary consideration from MWHA as part of the negotiation process for the merger and that the request was denied. Moreover, given the dire financial straits of the hospital, the Board concluded that the Provider had less than one month of payroll on hand and bankruptcy was looming. Therefore, the Board concluded that the Provider made the decision to merge with the one entity willing to acquire the hospital before the facility would have entered bankruptcy and been forced to close. The Board states that the Provider did contact other hospitals to explore the potential for merger. However, MWHA was the only party interested in a merger. The Board viewed the $19 million dollar assumption of liabilities reflected the fair market value of the Provider operation at the time that the merger took place.

In this case, the record shows that the Provider transferred hospital assets that were not appraised before commencement with the merger negotiations. The Provider and WMHA apparently negotiated and conducted "due diligence" for over two years before a formal appraisal of assets was produced.[24] The appraisal report was

[24] During this time, the Provider commissioned a feasibility analysis regarding the opening of a SNF unit and financed the opening of SNF facility unit just months

submitted on December 10, 1996. The record shows that the letter of intent to purchase between the Provider and MWHA was signed as early as June 1994. The Provider and MWHA entered into a Memorandum of Understanding regarding the merger on October 12, 1995. On July 31, 1996, a Plan and Agreement of Hospital Merger was signed, and on August 1, 1996, the Articles of Merger were filed. The fact that the existing asset appraisal was generated by the Provider almost four months after the merger, despite the two years of negotiations, does not support the claim that the Provider was seeking to obtain the best price for its assets.

Based on this fact, it is reasonable to conclude that the Provider was not concerned about assessing or ensuring that the transaction was for "reasonable consideration." The absence of a calculation and determination of the value of the Provider's assets by the Provider before commencement of the transaction, to ensure that such assets were transferred to MWHA for reasonable consideration is evidence that the Provider was not involved in a bona fide sale that involved bona fide bargaining at arms' length between well-informed parties, each acting in its own self interest. In addition, the record shows that the primary motivation for seeking a partner was "long term survival."[25] The Provider was focused on transitioning its debts and assets to MWHA to enable its organization to continue operations under a new name and company umbrella, while continuing the same mission and operations and service to its community.

The record also shows that the Provider transferred a combination of current, fixed depreciable assets and cash assets, with a net book value of approximately $37,012,827 in exchange for the surviving entity's assumption of liability of approximately $19,133,433.[26] The $37 million was the total net book value of approximately $14.5 million for property, plant, and equipment, $12.2 million for total current assets, $6.8 million for total designated assets and other assets of $3.4.million.[27] The Provider stated that the combination of the physical plant, land and equipment was only appraised for $4.9 million,[28] in contrast to the $14.5

---

before the merger. This conduct is more consistent with an entity that is going to continue after the merger and has a stake in the future of the surviving entity.

[25] *See* e.g. Provider Final Position Paper, p.7.

[26] Provider Exhibit P-58. Provider's Financial Statement, July 1996. See also Provider Exhibit P-101.

[27] Provider Exhibit P-58. The Provider argued that certain assets were restricted and hence could not be liquidated, but the lack of liquidity does not reduce the dollar for dollar value of funds such as funded depreciation, etc..

[28] Provider Exhibit P-14. The appraisal does not use the cost approach in order to value the depreciable assets. The Administrator finds that the reproduction (replacement) cost approach assigns a value to each individual asset which is

million net book value. Thus, it would argue that it transferred depreciable assets of almost $5 million in exchange for the transfer of $19 million in debt. However, regardless of the value of the depreciable assets and land, even if imputed as zero, the Provider's financial statement shows that the total value of the assets that were transferred exceeded the liabilities by a minimum of almost $3 million. If the net book value of the depreciable assets of $14.5 million is removed from the $37 million total net book value of all of the Provider's assets, the remaining Provider assets have an approximate value of $22.5 million, while all the assets were transferred for the assumption of $19 million in liabilities.[29] Such a transfer of assets in essence resulted in a donation of the Provider's depreciable assets through a merger with the surviving entity for which no loss can be recognized.[30] In the least it shows that no reasonable consideration was paid for the transfer of the assets to the surviving corporation.

Since there was a significant disparity of consideration tendered in exchange for the Provider's assets amounting to a donation, the transaction in essence amounted to a combination between the two parties, rather than a *bona fide* sale of assets. In sum, as noted above a bona fide sale must be for reasonable consideration. Thus, the Administrator finds that the transaction was not a bona fide sale as required under the regulations and PRM for the recognition of a loss on the disposal of assets.

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. The Administrator concludes that this further supports a finding that no loss is to be calculated under the facts of this case. If one were to assume that the assumption of liabilities

---

necessary under the Medicare rules and, thus, is necessary for the determining of the fair market value of the various depreciable assets. As noted in the PM A-00-76, the replacement cost/cost approach is the most appropriate methodology to use in establishing the fair market value of assets sold for the purpose of a bona fide sale analysis. The cost approach is generally viewed as the only reliable approach when dealing with special use properties or when there is a lack of market activity as here. Moreover, the appraisal was based on an alternative use for the hospital land and building based on lots for residential use, not for commercial use as might be expected and the rental value of the shell. Finally, as the appraisal did not use the cost approach, or the income approach for the appraisal of the hospital building, there was no comparison for testing the validity of the sales approach.

[29] Provider Exhibit-58, Provider Exhibit-101.

[30] *See* 42 CFR 413.134(b)(8) and *supra* n.7.

would be the basis for any loss, as the Board in the past has recognized, a well run and performing hospital corporation may well experience a greater "loss" on depreciable assets, than the poor performing hospital corporation. The Administrator finds that there is an obvious flaw in finding this merger 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 and highlights the pruoses of the bona fide sale provision.[31] There is no explicit regulatory directive applying a special rule for consolidation of non-profits that rewrites the related party rules, the loss on sale rules, or the rules controlling the calculation of a loss that would allow this end result proposed by the Board.

As set forth in the PRM at §104.24, reasonable consideration is a required element of a bona fide sale. The transaction in essence amounted to a combination between the two parties, rather than a bona fide sale of assets. Thus, the Administrator finds that, that the transaction was not a bona fide sale as required under the regulations and PRM for the recognition of a loss on the disposal of assets.

B. Continuity & Control

Furthermore, the Administrator finds that there was a continuity of control that resulted in the parties to the merger being related. As discussed above, a provider may not claim a loss on depreciation if the sale was between related parties. The Administrator finds that the relationship of the parties both pre and post-merger is relevant to assess continuity and control. In this case, the record shows that there was a carry forward of top executives and board members pre and post affiliation

[31] As a result of the exclusion of non-profit combinations from the scope of FASB No. 141 (the replacement guidance for APB No. 16), the Financial Accounting Standards Board (FASB) has undertaken a project to develop guidance on combinations of not-for-profits organizations. In a June 20, 2003 update, the FASB also recognized the fact that non-profit business combinations can result in no dominate successor corporation (contrary to an underlying presumption on removing the pooling of interest under FASB No. 141). The FASB also noted that: "Combinations in which the acquiring entity is an [not-for-profit] NFP organization unlike combinations in which the acquiring entity is a business enterprise, cannot be assumed to be an exchange of commensurate value. Acquired NFP organizations lack owners who are focused on receiving a return on … their investment … [T]he parent … of an acquired NFP may place its mission effectiveness ahead of achieving maximum price…." Such was also pointed out by CMS in its PM in explaining why a consolidation/merger between not-for-profits may not result in any loss or, in the least, an accurate determination of a loss.

that maintained the influence of the Provider and its parent company. In addition to the lack of evidence of a bona fide sale, the evidence of a combination or the pooling of interests, becomes even more evident when the percent of corporate officers, directors and board members that transitioned from positions within the Provider's entity to new positions within WMHA are taken into consideration.

The Provider management was comprised of a Board of Trustees and a Board of Management. The function of the Board of Trustees was to meet once a year and elect a Board of Management. The Trustees themselves were elected by the members of the Provider, Whidden Memorial, which was comprised of over 100 individuals drawn from the local community who met once a year for the purpose of electing the Trustees.[32] The Board of Management meet monthly and generally exercised the governance powers and responsibilities of the board of trustees.

The composition of the Provider's Board of Trustees and management before the merger and the composition of the surviving entity after the merger showed a continuity of control of the assets which were the subject of the transaction.[33] The Provider, Whidden, had 16 individuals on its Board of Trustees. After the merger, the Board of Trustees of MWHA and the Parent corporation, UniCare, consisted of 60 members of which 11 members had previously been members of the Board of Management of Whidden Memorial. In addition, another seven members of the initial 60 member Board of Trustees for both MWHC and UniCare were named from the individuals also named/designated as members of UniCare by Whidden. This brought the total representation of the Provider and its related designees to approximately 18 members or 30 percent of the Board of Trustees.[34] In addition, after the merger the Executive Committee of the surviving entity consisted of 24 members. Of the 24 members, at least eight were from the Provider's former Board of Management or had been designated as a member of UniCare and formerly affiliated with the Provider, Whidden, thereby, making the Provider's total representation as 30 percent of the post merger Executive Committee.

Two individuals formerly associated Whidden were appointed as officers in the merged corporation: one as Secretary Clerk; the other as First Vice-Chairman. Two individuals formerly associated with Whidden were appointed as officers in the parent company UniCare Health System; one as Secretary Clerk; the other as

---

[32] *See e.g.* Provider Exhibit P-102 Affidavit of Ross T. France at p. 5.
[33] *See e.g.* Intermediary Exhibit I-57, I-58 at 7-8,9,10, Parties Stipulation
[34] The Intermediary also pointed out that the representation would be higher if pre-1996 former board members were included along with new board members related to prior board members of the Provider.

First Vice-Chairman.[35] In addition, after the merger, 101 former members of the Provider were added to the existing membership of the Melrose-Wakefield parent corporation or UniCare Health Systems, Inc., for a total membership of 346 members.[36] The Administrator finds that the Provider's 30 percent continued representation on the various boards approximated the percent of assets and revenue production that it brought to the merger at the time of the negotiations, that is its percentage of ownership of the total assets of the merged entity.[37]

In sum, the Administrator finds that, as the merger did not involve an arm's length transaction, between unrelated parties for reasonable consideration, with each party acting in its own self interest, a loss cannot be allowed in this case. As a loss is not allowable in this case, the Administrator does not reach the issue of how to calculate the loss.

ISSUE NO. 2 DISCUSSION

Since its inception in 1966, Medicare's reimbursement of health care providers was governed by §1861(v)(1)(A) of the Social Security Act, which provides that:

> reasonable cost of any services shall be the cost actually incurred, excluding there from any part of incurred cost found to be unnecessary in the efficient delivery of needed health services….

However, the Secretary has also been granted authority under §1861 (v)(1)(A) of the Act to establish:

---

[35] The record does not show the composition of the two separate hospital management staffs after the merger.

[36] *See e.g.* Intermediary Exhibit I-59. The Agreement provided that at the time of the merger the membership of the parent corporation shall be expanded to include persons who prior to the effective date were incorporators or members of the Parent corporation, MWHA and the Provider; who were otherwise affiliated with the Provider and its affiliated entities or who were representatives of the communities served by the parent corporation and the hospital's corporation.

[37] *See e.g.* Provider Exhibit P-10, B-6, B-7 projecting Whidden Assets for 1995 of $34 million/liabilities of $19 million and MWH with assets of approximately $92 million/liabilities of $42 million.

> limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title….

Implementing §1861 (v)(1)(A) of the Act, the Secretary has promulgated the regulation at 42 CFR 413.30 which sets forth the general rules under which CMS may establish payment limits on the reasonable costs of providers. The regulation further establishes rules which govern exemptions from and exceptions to limits on cost reimbursement in order to address the special needs of certain situations and certain providers. In this case, the Provider requested an exemption from the cost limits for new providers. The exemption is set forth in the regulation at §413.30(e) which reads:

> Exemptions from the limits imposed under this section may be granted to a new provider. A new provider is a provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years. An exemption granted under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient. (1996)

As applicable to the issue in this case, the term "equivalent" in the regulation refers to whether, prior to certification, the institutional complex was providing skilled nursing care and related services for residents who required medical or nursing care, or rehabilitative services for injured, disabled or sick individuals.[38] When determining the character of a provider's present and previous ownership, CMS looks at the services of the institution as a whole prior to certification.

The Secretary recognized that "new providers" serving inpatients could face difficulties in meeting the application of the cost limits during the initial years of

---

[38] *See also* _Section 2533.1 of the PRM ('The term 'equivalent' refers to whether or not, prior to certification, the institutional complex engaged in providing either (1) skilled nursing care and related services for residents who request medical or nursing care; or (2) rehabilitation services for the injured, disabled, or sick persons identified in 42 CFR 409.33(b) and (c).) The term "equivalent" services was also addressed by the court in *St. Elizabeth's Medical Center of Boston, Inc., v. Thompson* (D.C. Cir. Feb. 4, 2005).

development due to underutilization. Consistent with the regulation, section 2604.1 of the PRM (1994)[39] states:

> A new provider is an institution that has operated in the manner for which it is certified in the program (or the equivalent thereof) under present and previous ownership for less than three full years. For example, an institution that has been furnishing only custodial care to patients for two full years prior to its becoming certified as a hospital furnishing covered services to Medicare beneficiaries shall be considered a "new provider" for three full years from the effective date of certification. However [for example], if an institution has been furnishing hospital health care services for two full years prior to its certification, it shall only be considered a "new provider" in its third year of operation which is its first full year of participation in the program.
>
> …
>
> Although a complete change in the operation of the institution … shall affect whether and how long a provider shall be considered a "new provider", changes of institution ownership or geographic location do not itself alter the type of health care furnished and shall not be considered in the determination of the length of operation.
>
> …
>
> However, for purposes of this provision, a provider which relocates may be granted new provider status where the inpatient population can no longer be expected to be served at the new location. The distance moved from the old location will be considered but will not be the determining factor in granting a new provider status…. A provider seeking such new provider status must … demonstrate that in the new location a substantially different inpatient population is being served. In addition, the provider must demonstrate that the total inpatient days at the new location were substantially less than at the old location for a comparable period during the year prior to the relocation. The periods being compared must be at least 3 months in duration. (Emphasis added).

---

[39] *See* 44 FR 15745, March 15, 1979 (Proposed Rule) and 44 FR 31802, June 1, 1979 (Final Rule).

The Administrator notes that §2604.1 was removed by Transmittal No. 400, dated September 1997, after the June 2, 1997 date of the exemption request.. The Transmittal stated that new §2533.1.A of the PRM set forth, inter alia, longstanding Medicare policy and explained that a new provider is an inpatient facility that has operated as the type of provider (or the equivalent) for which it is certified for Medicare under present and/or previous ownership for less than three years. Section 2533.1.B.1 explains that if the institution has operated as a SNF, or its equivalent, for three or more years, under past and/or present ownership, prior to Medicare certification, it will not be considered a new provider.[40]

Furthermore, when determining whether a provider is in fact, a "new" provider under the regulations, CMS considers whether the SNF in question was established through a change of ownership or "CHOW." Section 2533.1.E of the PRM explains that 42 CFR 413.30(e) requires CMS to examine the operations of the institution both under past and present ownership to determine if it is eligible for a new provider exemption. Paragraph E.1 explains the transaction types also discussed at sections 1500.1, *et seq.*, of the PRM and sets out specific examples. This includes an example set forth at paragraph E.1.b regarding the disposition of all or some of an institution or its assets used to render patient care. That paragraph states in pertinent part that:

> [A]n institution purchases the right to operate (i.e. a certificate of need) long term care beds from an existing institution...(be it opened or closed)[[41]] that has or is rendering skilled nursing or rehabilitative

---

[40] The PRM at §2533.1B3 also addresses the relocation exemption, stating in part that: (a)n institution … that has undergone a change in location may be granted new provider status when the normal inpatient population can no longer be expected to be served at the new location. In this case, the institution … must demonstrate that in the new location a substantially different inpatient population is being served…. The normal inpatient population is defined as the health service area (HSA) for long term care facilities, or its equivalent, as designated by the State planning agency or local planning authority in which the institution…. is located."

[41] Section 2533.1.F also sets forth examples of the effect of decertification, closure, replacement, remodeling or additions to existing institutions for new provider exemptions. Paragraph F.3 explains that an institution that operates as an SNF or its equivalent must cease operations for three full years prior to the date the institution recommences operation as a SNF or it equivalent to be granted a new provider exemption.

> services to establish (in whole or part) a long term care facility or to enlarge an existing long term care….

The longstanding policy set forth at PRM at §1500 gives several examples of CHOW transactions and explains that:

> Most of the events described represent common forms of changes of ownership, but are not intended to represent an exhaustive list of all possible situations…. The described events are not intended to define changes of ownership for purposes of determining historical costs of an assets or the continuation of the provider agreement.[42]

Notably, §1500.7 describes an example of a CHOW transaction as the:

> Disposition of all or some portion of a provider's facility or assets (used to render patient care) through sale, scrapping, involuntary conversion, demolition or abandonment if the disposition affects licensure or certification of the provider entity.

Likewise, the Court of Appeals in *South Shore Hospital, Inc. v. Thompson*, 308 F.3d 91 (1st Cir. 2002), determined that in order for a CHOW to be found, the transfer of the assets must "affect" licensure or certification, "not that it be the dispositive factor." The Court found that: "Here the DON rights were a sine qua non for the operation of a nursing home…."

In finding that a CHOW occurs when the beds are transferred, the Secretary has explained that a transfer of such rights does not result in the provision of any new services. Even though the transferee might have new equipment, staff, etc., it will provide the same kind of services as the transferor of the certificate of need or CON rights, just at a different location. The Court of Appeals in *Paragon Health Network, Inc.*, 251 F.3d 1141 (2001), refused to find unreasonable the Secretary's interpretation that, where bed rights are transferred, there are no new services being provided and, thus, there is no new provider. In addition, the Court of Appeals aptly stated in South Shore that:

> To sum up, we find no plausible reason to discredit the Secretary's rationale that, when a facility purchases another's [CON] rights in a moratorium state, lessened competition will enhance initial utilization…. On that rationale it makes sense, for purposes of

[42] Rev. 332 (1985).

> construing the new provider exemption, to attribute the operations of the seller to the acquirer of the DON rights.

The Administrator finds that CMS' policy regarding CHOWs in the new provider exemption context is also related to the purpose of the exemption, e.g., to grant relief for underutilization. As the Secretary reasoned and the Court of Appeals concurred in *Paragon*:

> At the time in question, SNFs were reimbursed under Medicare the lesser of the reasonable cost of or the customary charge for the service in question…. The definition of "reasonable cost" excludes any "cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. §1395x(v)(1)(A). The Secretary contends, as with the textual argument above, that the transfer of CON rights simply shifts around SNF services. Creating a new facility and moving services to it, … is costly, but no benefit is gained in the overall delivery of health services if the new facility is providing the same services to the same populace as the old one. Thus, the Secretary's judgment that the high start-up costs of [the provider] were "unnecessary in the efficient delivery of needed health services" is a reasonable one that will not be disturbed by this court. *Id.* at 1150-1151.

ISSUE NO. 2 FINDING OF FACTS AND CONCLUSION OF LAW

The Provider a distinct part unit, opened its hospital-based skilled nursing facility (HBSNF) on March 4, 1996 in accordance with the requirements established by the State of Massachusetts for licensing long-term care facilities.

In this case, the Provider entered into a contractual agreement on June 29, 1995 with Care Well Manor Nursing Home, Inc., an unrelated Level III facility located in Malden, Massachusetts, after arranging for a feasibility study and a management contract for its unit. As a result of the agreement Care Well Manor surrendered its license to operate its 23 bed facility and the provider purchased the rights to operate Care Well's 23 beds for $300,000.[43]

On October 6, 1995, the Provider filed a license application In July of 1995, to maintain a nursing home named and described as "Care Well Manor Nursing

[43] See, Provider Exhibit P-12 at 1. Intermediary Exhibit I-4 (Provider's exemption request)

Home Inc., for a transfer of ownership, which was effective October 4, 1995 for 23 level II beds.[44] On October 6, 1995, the Provider filed a State license application. The State's Notice of Determination of Need, dated September 20, 1996 stated the following reasons for the notice that: a binding contractual commitment was entered into with a nursing home licensed under the State law that resulted in a surrender of its license; that the nursing home has ceased operation of its facility; that the hospital has developed a hospital-based nursing facility and meet the qualifications for licensure and Medicare certification and that the hospital has agreed to be responsible for all overpayments owed the State's Division of Medicaid Assistance by the nursing home which has surrendered its license.[45] The determination of need was effective March 4, 1996. On March 4, 1996, the HBSNF began operations. A Medicare Participation agreement was effective March 8, 1996.[46]

In order to establish a SNF in the State of Massachusetts, a provider must possess a determination of need (DON) from the Massachusetts Department of Public Health (DPH) granting it the legal right to establish a long-term care facility with a specified number of beds. In 1994, the DPH adopted a policy that would allow hospitals to establish a HBSNF by permitting the hospitals to enter into agreements with existing Level III nursing homes in order to purchase the operating rights to Intermediate Care Facility (ICF) licensed beds. The DPH established this policy to further the development of subacute services and to allow Level III providers to orderly exit the Long Term Care (LTC) industry. The purchase results in the nursing home surrendering the operating rights related to its beds to the purchaser, transferring its patients to suitable other providers, and then closing the facility. Upon the closure of the Level III facility and completion of renovations at the hospital, DPH grants the hospital a new license for a new facility (i.e. Level II HBSNF). In July 1996, the Massachusetts legislature established an alternative basis for the issuance of DONs. Under the 1996 Mass. Acts Ch. 203 section 31, any hospital which was issued a DON under the previous process would have its prior DON superseded and replaced pursuant to the 1996 DON Act. Accordingly, on September 20, 1996, the Massachusetts DPH superseded the prior licensure that the Provider had opened and operated under since March 1996, and replaced it with a DON under the 1996 Don Act.

---

[44] Intermediary Exhibit I-4, Attachment E. Care Well was a 23 bed facility. The Provider determined that 20 beds was the most efficient number for a transitional care unit.

[45] Intermediary Exhibit I-4, Attachment A.

[46] Intermediary Exhibit I-4, Attachment B.

On June 2, 1997, the Provider submitted an application requesting a new provider exemption from the SNF routine cost limits effective through the cost reporting period ending September 30, 1999. On August 21, 1997, the Provider was notified by its Intermediary that CMS had denied its request for a new provider exemption on the basis that the Provider did not meet the criteria for a new provider.[47] The CMS denial found that as Whidden Memorial Hospital transitional care unit was part of a hospital that had merged with Melrose Wakefield Hospital effective July 31, 1996. Thus as where Melrose Wakefield already operated a hospital-based SNF, Whidden was not eligible for a new provider exemption to the Medicare SNF routine service limits.[48]

First the Administrator finds that, as the record already established in this case indicates, the Provider SNF unit was certified and operated as a SNF beginning in March 8, 1996, while the merger did not occurred until July 31, 1996.[49] Therefore, the CMS denial was erroneously based on the merger, as the issue is whether the Provider was eligible for a new provider exemption on March 8, 1996, prior to the merger.[50] Only where a Provider is granted a new provider exemption, will CMS revisit the granting of the exemption in the event there is a change in circumstances in subsequent periods. Thus, an examination would have been premature as to whether a new provider exemption is properly granted in light of the merger. The Administrator also notes that in its request for a new provider

---

[47] The Provider submitted and was granted an atypical service exception for the cost years at issue.

[48] Intermediary Exhibit I-5.

[49] While the Provider SNF subunit was initially identified as having a cost reporting period ending September 31, 1996, (See Exhibit I-4, Exhibit B), the Provider's (Whidden) terminating cost reporting period is July 31, 1996 due to the merger and hence that of the Provider subunit. (See Intermediary Exhibit I-8) which identifies the Whidden Transitional Care Unit (Provider No. 22-7193) (certified 03/08/96) as part of the Hospital complex. The Provider appealed the cost reporting period October 1, 1995 through July 31, 1996 by letter dated March 5, 1999 and March 16 1999. A July 26 1999 Board letter corrected the Provider's request to have the new provider exemption issue added to FYE 1997, instead of adding it to the FYE 07/31/1996 as the initial year of the denied of the three year exemption period.

[50] Prior to the merger, the SNF subunit was initially identified as having a cost reporting period ending September 31, 1996. (See Exhibit I-4, Exhibit B) The Provider's (Whidden) terminating cost reporting period is July 31, 1996 due to the merger. (See Intermediary Exhibit I-8) and also became the ending cost reporting period for Whidden Transitional Care Unit (Provider No. 22-7193) (certified 03/08/96) as part of the Hospital complex cost report..

exemption, the Provider, while providing a narrative in the cover letter that discussed Care Well, in the actual "SNF Exemption Request Information Needs," form erroneously answered "no" to the Question No. 11 which asks: "Has this long term care institution purchased beds from another private long term care institution, a Medicare certified skilled nursing facility, a Medicaid certified nursing facility … to establish or enlarge this long term care institution?" The "SNF Exemption Request Information Needs," which is the form used by CMS to obtain information necessary to make a determination as to whether the Provider qualifies as a new provider, contains no reference to Care Well and the level of care provided at Care Well.

Generally, under these circumstances a remand would be appropriate to allow CMS to make a determination based on the development of the correct facts. However, such a remand would delay the resolution of the entire case. In addition, the parties and CMS have briefed the issue fully as to a denial on the alternative grounds involving the impact of Care Well on the granting of a new provider exemption and, to the extent possible, developed the factual record on that alternative grounds for a decision.

Under the regulations at 42 C.F.R. 413.30(e), a "new provider" is a "provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years." The Provider Reimbursement Manual states that the disposition of all or some portion of a provider's facility or its assets used to render patient care through sale is a change of ownership for purposes of Medicare reimbursement if the disposition affects licensure or certification. A certificate of need (CON), or in this instance, a DON, is an asset used to render patient care that directly affects licensure and certification of a provider entity.

Where the right to operate, or its equivalent, is purchased from an existing institution, the transaction is considered a change of ownership and review of the "previous owner's" operations become necessary. Therefore, in this case, the Provider is required to document the types of care or services rendered under present and previous ownership so that the Intermediary can determine if the facility provided services equivalent to skilled nursing care and related services for three or more years prior to being certified to participate in the Medicare program.

There is no dispute that the Provider sought a DON from the State of Massachusetts for the 23 beds skilled nursing beds. The record reflects that the 23 beds that were transferred and relocated to the Provider through the approval of the Provider's DON existing beds of a Medicaid certified nursing facility (NF) formerly owned and operated by Care Well. As the Administrator determines that

the transfer of the DON originally owned by Care Well represents a change of ownership, the regulation requires a "look back" as to the type of services provided by the prior owner.

Although the Provider did not obtain all of the assets from Care Well, it did obtain a portion of that institution's assets (used to render patient care), i.e., operating rights to 23 SNF beds, which the disposition thereof affected licensure or certification of the provider entity. The purchase of "rights to operate" does constitute a CHOW and does affect the Provider's right to a new provider exemption. The change in the Massachusetts State statute that had the effect of granting the provider operating rights directly from the State does not distinguish this case from others in which the Secretary's interpretation has been upheld.[51]

A CON/DON is an asset used to render patient care and the transfer of a CON/DON constitutes a CHOW transaction for purposes of determining whether the Provider qualifies for an exemption as a new provider. This finding is consistent with §§1500 and 2533 of the PRM which define the disposition of all or some portion of an institution or institutional complex or its assets used to render patient care through sale, scrapping, involuntary conversion, demolition, or abandonment if the disposition affects licensure or certification of the institution as a CHOW. Likewise, under the CHOW provisions, whether the transfer of the beds or CON/DON rights was a result of a sale, donation, or scrapping, is not the sole determinative factor in assessing whether a CHOW has occurred for purposes of the new provider exemption.[52] As reasoned by the Secretary and concurred by the court in *Paragon* :

---

[51] *See South Shore Hospital, Inc. v. Thompson*, 308 F.3d 91 (1st Cir. 2002) involving a Massachusetts hospital and a Level III Medicaid nursing facility (NF) which CMS found had operated as the equivalent of a certified Medicare SNF. *See also, Paragon Health Network, Inc. v. Thompson*, 251 F.3d 1141 (2001). In finding that a CHOW occurs when CON rights are transferred, the Secretary explained that a transfer of CON rights does not result in the provision of any new services. Even though the transferee might have new equipment, staff, etc., it will provide the same kind of services as the transferor of the CON rights, just at a different location.

[52] In contrast, the nature of the transaction underlying the transfer is relevant, with respect to depreciable assets, because of the rules on gains and losses on the disposal of assets. 42 C.F.R. 413.134(f). Section 4501 of the Intermediary Manual notes that each potential CHOW transaction is subject to two reviews under the Medicare program; one for the certification and, one for Medicare reimbursement.

> At the time in question, SNF's were reimbursed under Medicare the lesser of the reasonable cost of or the customary charge for the service in question. [] 42 U.S.C §1395f(b)(1) (1994). The definition of "reasonable cost" excludes any "cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. §1395x(v)(1)(A). The Secretary contends, as with the textual argument above, that the transfer of a CON rights simply shifts around SNF services. Creating a new facility and moving services to it, … is costly, but no benefit is gained in the overall delivery of health services if the new facility is providing the same services to the same populace as the old one. Thus, the Secretary's judgment that the high start-up costs of [the provider] were "unnecessary in the efficient delivery of needed health services" is a reasonable one that will not be disturbed by this court. *Id.* 1150 - 1151.

A review of the record reflects that the subject beds were previously owned and operated by Care Well. As such, Care Well's operation as a Medicaid nursing facility that provided services equivalent to a SNF is directly attributable to the determination of whether the Provider satisfies the "new provider" exemption under the 3 year "look back" rule. The argument, raised by the Board, that the Provider is a "new provider" based on the Massachusetts legislature's establishment of an alternative basis for the issuance of DONs retroactively, does not supersede or negate the effect of Care Well's operational status on the determination of Provider's exemption request. Despite the Board's attempt to use the new State legislation to prohibit the look back to the "previous owner", the Administrator finds that Care Well's prior history as a NF is directly relevant to the Provider's status as an existing provider beyond the 3 year period.[53] Moreover, the determination of the Provider's status as a "new provider" is based on statutory and regulatory provisions established by Congress and subsequently interpreted and administered by the Secretary through CMS. The authority to create and determine whether the Provider classifies as a "new provider" for Medicare reimbursement purposes, and receive exemption from Medicare law is a Federal function that cannot be controlled by State law.[54] Thus, the Board conclusion that there were no prior owners of the DON reissued by the State on September 20, 1996 and after the Provider HBSNF was already operating, incorrectly ignores the

---

[53] The Administrator finds that the statutory change that had the effect of granting the Provider operating rights directly from the State does not distinguish this case from the others in which the Secretary's interpretation has been upheld. *See*, *South Shore Hospital, Inc. v. Thompson*, 308 F.3d 91 (1st Cir. 2002), *Providence Health System v. Thompson*, 353 F.3d 661 (9th Cir. 2003), and Paragon, supra.

[54] *See Erie RR v. Tompkins*, 304 US 64 (1938).

record evidence that the beds were previously owned by Care Well and obtained by the Provider through a purchase agreement.[55]

As a matter of law, the Administrator finds that, as Care Well was a certified Medicaid nursing facility provider for at least three years during the "look back" period prior to the transfer of the bed rights, the prior owner operated as an equivalent provider of services to a SNF. The Omnibus Budget Reconciliation Act of 1987 included the Nursing Home reform provisions that regulate the certification and operation of long term care (LTC) facilities under the Medicare and Medicaid programs. These provisions became effective for services rendered on or after October 1, 1990. Congress' intent in adopting these provisions was to establish uniform certification standards for all Medicare and Medicaid facilities. The result is that both Medicare SNFs and Medicaid NFs are required to provide directly or indirectly, the same basic range of services. These ranges of services include those nursing services and specialized rehabilitative services needed to attain or maintain each resident's highest practicable level of physical, mental, and psychosocial well-being.

Further, relevant to the new provider exemption in this case, CMS issued a Trans. No 400 which further discussed the "SNF and its equivalent defined."[56] Section 2533.1.G explains that:

> The following are examples of institutions or institutional complexes that are considered to be equivalent to an SNF, but are not intended to represent all possible situations:
>
> a. An institution or institutional complex operated, or operated as a, nursing home not certified for Medicare, Medicaid, or title V, providing skilled nursing or rehabilitative services.
>
> b. An institution or institutional complex operated, or operated as a, Medicaid certified long term care facility providing skilled nursing or rehabilitative services (i.e., nursing facility as defined under §1919 (a) (1) of the Act).

---

[55] Intermediary Exhibit I-4, Intermediary Exhibit I-17.

[56] The Trans No. 400 clarified and restated longstanding policy.(Sept 1997) ("Existing policies and statutory provision continue in effect effective 30 days from August 20, 1997. New polices on the effect of a change of ownership on an approved 0065cepotion as outlined in section 2533.1E.2 are effective 30 days from August 20, 1997 for all exemptions still in effect.")

> The Omnibus Budget Reconciliation Act of 1987 includes the nursing home reform provisions that regulate the certification of long term care facilities under the Medicare and Medicaid programs. These provisions are effective for services rendered on or after October 1, 1990. Congress' intent in adopting these provisions was to establish uniform certification standards for all Medicare SNFs and Medicaid nursing facilities (NF). The result is that both Medicare SNFs and Medicaid NFs are required to provide directly or under arrangements the same basic range of services described in §1819 (b) (4) and §1919 (b) (4) of the Act in order to be certified for Medicare or Medicaid. This range of services includes those nursing services and specialized rehabilitative services needed attain or maintain each resident's highest practicable physical, mental, and psychosocial well-being. Therefore, the range of services that a Medicaid NF must provide to be certified includes the same types of services offered in an SNF th at is certified for Medicare.

As the court in South Shore noted:

> The Hospital suggests three ways in which the [Secretary] may have embarrassed the substantial evidence standard. First, the Hospital asserts that because the new provider exemption makes no explicit allowance for facilities as disparate as Prospect Hill [prior owner] and the TCC [present owner], such facilities necessarily must lie outside the ambit of the equivalency rubric. Second, the Hospital contends that in order to be an equivalent of an SNF, a facility would have to meet the definition of an SNF—and Prospect Hill did not. Third, the Hospital posits that, given the underlying policy of the new provider exemption, Prospect Hill's sporadic deployment of skilled nursing services simply does not justify a finding of equivalency.
>
> All three of these arguments miss the essential point. The Secretary, in his discretion, reasonably could have looked not at the particular level of care provided by a nursing facility, but, rather, at a broader definition of equivalency. Although our review is geared to whether the Secretary's decision rests on substantial evidence, we must in the process defer to what the Secretary reasonably found to be relevant. To do otherwise would fetter the Secretary's discretion in an unwarranted manner…..
>
> The Board [acting for the Secretary] accepted this premise—and reasonably so. In the process, it cited specifically to the nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987

> governing the certification of long-term care facilities under Medicare and Medicaid….. These provisions indicate that both Medicare SNFs and Medicaid nursing facilities provide the same basic range of services. See S. Shore I, supra, at *14, *17 (explaining that these provisions require both Medicare SNFs and Medicaid nursing facilities to provide the range of services described in sections 1819(b)(4) and 1919(b)(4) of the Social Security Act). Thus, Prospect Hill, as a Medicaid facility, "would have already incurred the start-up costs associated with the development of the capacity to furnish inpatient SNF services, by meeting the requirements for participation." Id. at *2.
>
> This is a convincing argument. Faced with it, we decline to substitute our judgment for the Secretary's as to whether so broad-gauged a comparison contradicts the underlying purpose of either the challenged regulation or the enabling statute.

In contrast to the policy set forth by CMS in regards to the "SNF and its equivalent" and adopted by the court in *South Shore*, the Administrator recognizes that the Court of Appeals in *St. Elizabeth* articulated a different standard based on whether the prior owner was "primarily engaged" in providing skilled nursing or rehabilitative services. Regardless of the standard to be applied, under the APA, the Provider in this administrative proceeding, where it is proponent of the rule, has the burden of proof to demonstrate by a preponderance of the evidence that Care Well was not operating as an equivalent provider. If one applies the alternative "primarily engaged" standard articulated by the Court in St. Elizabeth, the only specific patient documentation submitted by the Provider in its exemption request regarding the provision of prior skilled nursing services was for services rendered on or after March 4, 1996, by the Provider. The Provider also alleges that all individual patient care records were destroyed and did not present any other patient records that preceded its ownership of the bed licensing rights.

The Administrator finds, based on this burden of proof, the Provider cannot prevail by default in lieu of the absence of the individual patient care records.[57] The only records available that are contemporaneous with the three year look back period,

[57] The level of individual patient medical record review required of the court's decision in *Milton* underlies the practical difficulty of applying this standard as the medical records are generally under a third party's control with which in most cases only the Provider has had a contractual relationship in purchasing the beds (and not CMS). Hence, the burden is for that reason also most appropriately placed on the provider under this standard.

that also indicates the level of patient care, are the Massachusetts Medicaid Management Minutes Questionnaire (MMQ). The MMQ documents filed by Care Well with the State of Massachusetts Department of Public Welfare for purposes of Medicaid reimbursement contain definitive evidence that the facility was "primarily engaged," [in its entirety or a distinct part thereof,] in the provision of the equivalent of skilled nursing care and related services for more than three years prior to the March 4, 1996 licensure date. Based on, among other things, the MMQs, the portion of the patient population receiving skilled nursing and related services or rehabilitative service[58] was 52 percent in FY 1992, 71 percent in FY 1993, and 73 percent in FY 1994.[59] Therefore, since the equivalent of skilled services and related services or rehabilitative services were provided to Care Well residents, the Administrator concludes that Care Well was "primarily engaged" in operating a SNF under the *St Elizabeth* standard.[60]

The Provider, in order to support its contention that Care Well was not operating as a SNF (or its equivalent) for three years prior to the change of ownership, submitted affidavits of the co-owners/of Care Well which was later followed-up with testimony. The Provider also submitted a revised Exhibit P-70 which was a summary of Exhibit P-71. This Exhibit "summarizes for each patient the various quarterly reports by date which reports did not include any entries for the patients for Items No. 2 (Skilled Observation), No. 11 (Skilled Procedure/Decubitis) or No.12 (Skilled Procedure/Other)." Revised Exhibit P-71 is thus contended to represent patients and periods for which patients received custodial care only.

---

[58] Skilled nursing care and rehabilitative services are, inter alia, furnished directly by or under the supervision of technical or professional staff such as registered nurses, licensed practical nurses, physical therapist, occupational therapists, speech pathologists or audiologists working under the direction of a physician.

[59] *See e.g.*, CMM comments, Attachment 1,, pp 7-10; Provider Exhibit P-71 (MMQ with patients identified by alphabet; Intermediary's position paper at pp 50-58, Intermediary Exhibit I-48 for Medicaid cost reports; Intermediary Exhibit I-18 (same MMQ reports).

[60] *See St. Elizabeth's Medical Center of Boston, Inc. v. Thompson*, 396 F. 3d 1228 (D.C. Cir 2005) as the controlling case where the D.C. Circuit Court established the "primarily engaged" rule to assess whether a prior owner was providing equivalent services under the "new provider" exemption status. *See also, Milton Hospital Transitional Care Unit v. Thompson*, 377 F. Supp. 2d 17, 27-28 (D.D.C. 2005) (citing cases), while non-binding, the D.C. District Court defined "primarily engaged" as at least 50 percent, based on case law regarding salesman.

Regarding the affidavits and testimony attesting to the level of care and services provided to patients at Care Well, the co-owners acknowledged that they were not involved with the patient care activities of the facility; that they did not review medical records; and did not know the specific medical needs of the individual patients.[61] In addition, in response to the Provider's revised Exhibit P-70, CMM provided a detailed analysis of the same patients, which shows, based on the best data available, that there were a significant number of patients in fact receiving skilled services and other related service, etc.[62] Consequently the Administrator concludes that the Provider failed to demonstrate by a preponderance of evidence that Care Well was not primarily engaged in providing SNF equivalent services.

Finally, the Administrator finds that the Provider does not qualify for an exemption based on the "relocation provision."[63] A provider that has undergone a change in location may be granted new provider status when the normal inpatient population can no longer be expected to be served at the new location. The provider must demonstrate that in the new location a substantially different inpatient population is being served. The normal inpatient population is defined as the health service area (HSA) for long term care facilities as designated by the State planning agency or local planning authority. If a provider relocates within the same HAS for long term facilities, it will not qualify for a new provider exemption, as the population normally served would continue to be expected to be served at the new location, unless it can demonstrate that 50 percent or more of its admissions are from a different HAS.

Care Well was located in the same HSA (HSA VI) as the Provider, thus the Provider would have to demonstrate that 50 percent or more of its admissions were from a different HSA. The Provider simply argues that seven percent of its

---

[61] *See e.g.* Tr. 120, 141, 142. The co-owner also contended that the MMQ instructions required that any services done by a licensed nurse was to be reported as a "skilled procedure", regardless of whether it was a skilled service, thereby suggesting that the MMQ was an inaccurate reporting device. However, such a contention is not supported by the MMQ instructions themselves. The owners also did not indicate that they were involved with the completion of the MMQ for Care Well.

[62] *See e.g.* CMM comments Attachment 1, pp 8-10, and Table 3 "Summary of Quarterly MMQ DAT submitted by Care Well manor Nursing Home for Reimbursement of Medicaid Covered Skilled Nursing Rehabilitative Services Provided to Medicaid Recipients by MMQ category." which also corresponds to patients identified by alphabet in Revised P-70, showing multiple refers to skilled care.

[63] *See* CMS Pub 15-1 §2604.1 of the Provider Reimbursement Manual.

patients come from the Malden area, therefore its serves a different inpatient population. The Provider erroneously argues that the type of patient was different and therefore it qualified for this exception. However, that is not the criteria to be met. The Administrator finds that the Provider has not provided the necessary documentation required to complete a relocation analysis that would satisfy the 50 percent or more admissions criteria either in its initial request, for which no location exception was requested, or in the subsequent record developed at the Board.[64]

In accordance with the foregoing, the Administrator finds that as the Provider does not qualify for a "new provider" exemption.

[64] While not pertinent to meeting the criteria for the new provider exemption or the relocation exception, the Administrator notes that any difference in the Provider's present patient population in comparison to Care Wells patient population is also reflective of the purpose for the Provider's establishment of a HB SNF, as opposed to a freestanding SNF, and ultimately the basis for an atypical exception request. The Provider's feasibility study shows that the Provider was principally focused on increasing the hospital profits generated from certain DRGs by reducing the hospital stays through the transfer of "sicker" atypical patients to the HBSNF that would provide easy access for the physicians, while also benefiting from the overhead allocation process of being part of a hospital complex. Therefore, because of the atypical patient mix, the Provider was granted an exception to the RCL limits, which was the appropriate relief to be granted instead of the new provider exemption.

DECISION

Issue No. 1

The decision of the Board, regarding Issue No. 1, is reversed in accordance with the foregoing opinion.

Issue No. 2

The decision of the Board, regarding Issue No. 2, is reversed in accordance with the foregoing opinion.

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

Date: 9/22/09

/s/
Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services