CENTERS FOR MEDICARE AND MEDICAID SERVICES
Order of the Administrator

In the case of:	**Claim for:**
Memorial Hermann Hospital **Provider** **vs.** **Blue Cross Blue Shield Association/** **Trailblazer Health Enterprises, LLC** **Intermediary**	**Reimbursement Determination** **For Cost Reporting Period** **Ending: November 3, 1997** **Review of:** **PRRB Dec. No. 2011-D23** **Dated: March 24, 2011**

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. The Provider and the CMS' Center for Medicare (CM) submitted comments. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND COURT DECISION

The issue is whether the Intermediary's adjustment, disallowing the loss claimed by Provider, was proper.

The Board held that the Intermediary's adjustments disallowing the Provider's claimed loss on the disposal of assets was proper. In reaching this determination, the Board first concluded that the Provider and Memorial Hermann Hospital System (MHHS) were unrelated parties as that term is defined under the regulatory provisions of 42 C.F.R. § 413.17 and § 413.134. The Board concluded that the regulation barred the application of the related party principle to the merging parties' relationship to the surviving entity.

Next, the Board held that HCFA Ruling 80-4 did not apply to the facts in this case. The Board stated that HCFA Ruling required consideration of the relationship between unrelated parties according to the new right created by their contract. The Board found that this was a one-time transaction with one of the parties ceasing to exist. There was no continuing relationship thereafter. Therefore, since no continuing relationship remained, there was no related party relationship under HCFA Ruling 80-4. The Board also held that PM A-00-76 was not a clarification of policy but a change in interpretation of the related party rules. The Board concluded that prior interpretations, relatedness for a merger transaction was determined solely on relationships prior to the merger. The Board concluded that the related party concept only applied to the entities relationship that existed prior to the merger and in the alternative, even if it did allow the examination post-merger, the facts do not support that the pre and post entities were related in this case.

Finally, the Board held that the transaction was not a *bona fide* sale as required under the regulations, the PRM and PM A-00-76 for the recognition of a loss on the disposal of assets. The Board first determined the basis for the "fair market value" of the assets. After consideration of many factors, including the lack of an appraisal, the Board determined that the net book value was the best evidence of the fair market value. In particular, the Board determined there was evidence that the depreciable assets increased in value in some respects, but decreased in others; that the owner's treatment of the assets for financial reporting purposes indicated that it did not perceive the fair market value to be materially less than the net book value (e.g., no recording of impairments) and that there was a lack of direct evidence as to fair market value. The Board concluded that the best evidence of fair market value was the $145 million of depreciable assets.

The Board noted that several Courts had upheld the Secretary's use of the *bona fide* sale provision found in PM A-00-76 requiring Intermediaries to determine whether the seller has obtained "reasonable compensation" for the depreciable assets sold. In this case, the Board found that the Provider had not received "reasonable compensation" for its assets. The Board noted that the allocation method used by the Provider, Accounting Principles Board (APB) Opinion 16 did not satisfy Medicare's valuation requirements. Accordingly, the merger was not a *bona fide* sale.

SUMMARY OF COMMENTS

Provider's Comments

The Provider submitted comments requesting that the Administrator affirm the Board's determination that the transaction was a merger between unrelated parties. Although the Board properly assessed the question of relatedness, it erred in finding that this merger would not meet the PM's *bona fide* sale requirements.

To support its contention that the Board erred, the Provider argued that the *bona fide* sale provisions in the PM imposed new requirements that were not contained in previous regulations or guidance. Under the rules in effect at the time of the merger, the Provider argues that if the transaction took the form of an assumption of liabilities in exchange for assets—with no additional payment made – then the "purchase price" was deemed to be the amount of liabilities assumed.

The Provider maintained that reasonable consideration was given because it would have violated the trustees' fiduciary duty to sell the estate's assets for less than their worth. Under Texas's fiduciary duties for trustees, a trustee selling trust property must use "care, skill and judgment toward obtaining fair market value[.]"[1] Thus, selling this property for less than fair market value would have breached the Trustees' fiduciary duties. Moreover, because the Probate Court and Attorney General approved of the merger, and because the Probate court found this merger consistent with fiduciary duties, the price and terms were necessarily fair market value. It is difficult to find more conclusive proof of a transaction's fairness than formal approval by a court and the highest legal office of the State.

The Provider also argued that the purchase price agreed upon by Memorial Hospital System (MHS) and the Provider resulted from a *bona fide* arm's length bargaining by well-informed parties acting in their own self-interest. As a result, reasonable consideration was paid. The Provider noted that during the hearing, testimony and exhibits showed why the purchase price (assumption of liabilities) was reasonable consideration. Much of this evidence related to the Provider's precarious financial condition – factors that tended to show that the Provider's assets would be worth less to a buyer than the amount at which they were carried on the books, and that expected expenses or revenue decline in the future would lower the amount that an informed buyer would pay for the Provider's assets.

Finally, should the Administrator find that the merger does qualify as a *bona fide* sale based on the evidence in the record showing an arm's length transaction for reasonable consideration and fair-market value, the Administrator should remand this matter to the Intermediary for any needed development of the fair-market value of the Provider's assets, and for calculation of the loss.

CM Comments

CM submitted comments concurring with the decision rendered by the Board but disagreed on the Board's conclusion that the regulation barred the application of the related party concept, to the merging parties' relationship post merger. CM asserted that

[1] *InterFirst Bank of Dallas v. Risser*, 739 S.W. 2d 882, 888-89 (Tex. App. 1987) (Provider's Exhibit P-57).

the applicability of the related party analysis is applicable to the relationship between the parties pre and post merger. As such, the Intermediary can review the relationship between the parties according to the subsequent rights created by their contract post merger.

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 CFR §413.130, which lists capital-related costs that are reimbursable under Medicare. Capital-related costs under Medicare include depreciation, interest, taxes, insurance, and similar expenses (defined further in 42 CFR §413.130) for plant and fixed equipment, and for movable equipment.

Title VI of the Social Security Amendments of 1983[2] added §1886(d) to the Act and established the prospective payment system (PPS) for reimbursement of inpatient hospital services provided to Medicare beneficiaries. Under this system, hospitals are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge according to a list of diagnosis-related groups. Reimbursement under the prospective payment rate is limited to inpatient operating costs. The Social Security Amendments of 1983[3] amended subsection (a)(4) of §1886 of the Act

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

to add a last sentence, which specifies that the term “operating costs of inpatient hospital services”, does not include "capital-related costs (as defined by the Secretary for periods before October 1, 1986)...." That provision was subsequently amended until finally, §4006(b) of OBRA 1987 revised §1886(g)(1) of the Act to require the Secretary to establish a prospective payment system for the capital-related costs of PPS hospitals for cost reporting periods beginning in fiscal year (FY) 1992.

1. Depreciation.

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

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

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

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

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

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

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

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

> The revision would describe the various types of disposal recognized under the Medicare program, and would provide for the proper computation and treatment of gains and losses in determining reasonable costs. [5]

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

> Existing regulations contain a requirement that any gain or loss realized on the disposal of a depreciable asset must be included in Medicare allowable costs computations… The regulations, however, specify neither the procedures for computation of the gain or loss nor the methods for making adjustment to depreciation. These amendments provide the rules for the treatment of gain or loss depending upon the manner of disposition of the assets. [6] (Emphasis added.)

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

> (1) *General*. Depreciable assets may be disposed of through sale, scrapping, trade-in, exchange, demolition, abandonment, condemnation, fire, theft, or other casualty. If disposal of a depreciable asset results in a gain or loss, an adjustment is necessary in the provider's allowable cost. The amount of a gain included in the determination of allowable cost is limited to the amount of depreciation previously included in Medicare allowable costs. The amount of a loss to be included is limited to the undepreciated basis of the asset permitted under the program. The

[5] 41 Fed. Reg. 35197 (August 20,1976) "Principles of Reimbursement for Provider Costs: Depreciation: Allowance for the Depreciation Based on Asset Costs." (Proposed rule.)
[6] 44 Fed. Reg. 3980. (1979) "Principles of Reimbursement for Provider Costs."(Final rule.)

> treatment of the gain or loss depends upon the manner of disposition of the asset, as specified in paragraphs (f)(2) through (6) of this section ….(Emphasis added.)

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

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

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

> A bona fide sale contemplates an arm's length transaction between a willing and well informed buyer and seller, neither being under coercion, for reasonable consideration. An arm's length transaction is … negotiated by unrelated parties, each acting in its own self interest.[7]

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

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

Paragraph (f)(3) addresses gains or losses realized from sales within 1 year after the provider terminates from the program, while §413.134(f)(4) addresses exchange trade-in or donation[8] of the asset stating that: "[g]ains or losses realized from the exchange, trade-

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

[8] A donation is defined in §413.134((b)(8). An asset is considered donated when the provider acquires the assets without making payment in the form of cash, new debt, assumed debt, property or services. Section 4502.12 of the Intermediary Manual states that

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

2. Revaluation of Assets.

Historically, as reflected in the regulation, the disposal of a depreciable asset used to render patient care may result in two separate and distinct reimbursement events: 1) the calculation of a gain or loss for the prior owner and 2) a revaluation of the depreciable basis for the new owner. While the determination of gains and losses is generally only of interest to the prior owner,[9] the new owner in the same transaction is interested in the determination of when Medicare will allow the revaluation of depreciation for purposes of calculating the new owner's depreciation expense.

This latter issue, on the revaluation of assets, was the subject of significant litigation for the Medicare program regarding complex transaction and resulted in agency rulemaking on the subject. In response to litigation, the regulations at 42 C.F.R .§413.134(l)[10] were promulgated to address longstanding Medicare policy regarding depreciable assets exchanged for capital stock, statutory mergers and consolidation. Concerning the valuation of assets, the regulation states that:

> (l) *Transactions involving a provider's capital stock—*
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> (2) *Statutory merger*. A statutory merger is a combination of two or more corporations under the corporation laws of the State, with one of the corporations surviving. The surviving corporation acquires the assets and liabilities of the merged corporations(s) by operation of State law. The effect of a statutory merger upon Medicare reimbursement is as follow:

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when a provider is donated as an ongoing facility to an unrelated party, there is no gain/loss allowed to the donor. The valuation of the assets to the donor depends upon use of the assets prior to the donation.

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

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

(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.

B. Related Organizations

The regulation at 42 C.F.R. § 413.134 references the related organization rules at 42 C.F.R. § 413.17. The regulation 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 (PRM), which provides guidelines and policies to implement Medicare regulations for determining the reasonable cost of provider services. In determining whether the parties to a transaction are related, the PRM at § 1004, et seq., establishes that the tests of common ownership and control are to be applied separately, based on the facts and circumstances in each case. With respect to common ownership, the PRM at § 1004.1 states:

> This rule applies whether the provider organization or supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or nonprofit. In the case of nonprofit organization, ownership or equity interest will be determined by reference to the interest in the assets of the organization (e.g., a reversionary interest provided for in the articles of incorporation of a nonprofit corporation).[11]

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

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

The related party organization was further explained in HCFA Ruling 80-4 which adopted the Eighth Circuit Court of Appeals' decision in *Medical Center of Independence v. Harris*, 628 F.2d 1113 (8th Cir. 1980).[12] The Ruling pointed out that the applicability of

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

[12] In *Medical Center of Independence v. Harris*, *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 42 C.F.R. §413.17, where the management

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, 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 than 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.

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

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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.

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. 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."[13]

In determining reasonable consideration, the PM stated that:

> Appraisals may be relied on to establish the fair market value of depreciable assets. (See PRM §134ff.) However, caution must be taken in evaluating the appropriateness of the valuations established by appraisal for the purpose of this comparison.
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> The three most common valuation methodologies are the "cost approach," the "market approach," and the "income approach." A single appraisal may use one or more of these methodologies to arrive at a valuation of the entity. The cost is the only methodology that produces a discrete indication of the value for the individual assets of the business, and thus, is the approach that is used to allocate a lump sum sales price among the assets sold. (See 42 CFR 413.134(f)(2)(iv).) The market approach produces an estimate of value by comparing the entity being valued to sales of similar businesses. The income approach produces a valuation through analysis of the predicted future stream of income. Both the market approach and the income approach produce a valuation of the business enterprise as a whole, without regard to the individual fair market values of the constituent assets. As a result, both the market approach and the income approach could produce an entity valuation that is less than the market value of the current assets. Moreover, the income approach has minimal application in the non-profit sector because 1) earnings are often understated due to charity care, pricing limitations, and government regulations, and 2) the approach uses complex formulae that include some factors that are of questionable use in valuing non-profit entities (e.g., common stock risk premium). For the foregoing

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

> reasons, the cost approach is the most appropriate methodology to be used in establishing the fair market value of the assets sold for the purpose of comparison with the sales price in a bona fide sale analysis.[14]

In summarizing, the PM stated, "An arm's length transaction is a transaction negotiated by unrelated parties, each acting in its own self interest in which objective value is defined after selfish bargaining." With respect to reasonable consideration, the PM stated that the sales price should be compared to the fair market value of the assets and that a "large disparity between the sales price (consideration) and the fair market value of the assets sold indicates the lack of a *bona fide* sale." Finally, the PM stated that the "cost approach" (rather than the "market approach" or "income approach") was the "most appropriate methodology to be used in establishing the fair market value of the assets sold for the purpose of comparison with the sales price in a *bona fide* sale analysis.

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).

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,

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[14] *Id*. at 4.

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,[15] 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,[16] Intermediaries are instructed to refer to the principles outlined in the CHOW manual which specify when reference to APB No. 16 is in accordance with the current Medicare policy.

Generally, APB No. 16 suggests two approaches to the treatment of assets when there is a business combination involving stock corporations: the pooling method and the purchase method. Historically, a combination of business interest was characterized as either a "continuation of the former ownership" or "new ownership." A continuation of ownership was accounted for as a pooling of interest. The pooling of interest method accounts for business combinations as the uniting of the ownership interests of two or more companies. No acquisition is recognized because the combination is accomplished without disbursing resources of the constituents and ownership interests continue. The pooling of interests method results in no revaluation of assets or recording of gains or losses. In contrast, "new ownership" is accounted for as a purchase. The purchase method accounts for a business combination as the acquisition of one company by another and is treated as purchase or sale. Thus, APB No. 16 is similar to the PM, in that both recognize and treat the pooling of interests in a business combination as an event resulting in no gain or loss, while

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[15] 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."

[16] 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).

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.[17] 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.[18]

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.[19] For example, a merger where the predecessor corporation board continues significant control in the new corporation board is treated the same as a reorganization for Medicare reimbursement purposes and no gain or loss is recognized. However, for example, where the predecessor corporation board does not continue significant control in the new corporation board, a gain or loss will be recognized for Medicare reimbursement purposes.

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[17] *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).

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

[19] *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.")

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.[20] (Emphasis added.)

Similarly, the courts have stated that the underlying purpose of the IRS provisions that find no gain or loss when there is a reorganization was twofold: "1) to relieve certain types of corporate reorganizations from taxation which seemed oppressively premature and 2) to prevent taxpayer's from taking losses on account of wash sales and other fictitious exchanges."[21] 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."[22]

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:

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[20] *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).

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

[22] *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)).

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

I. Findings of Facts and Conclusions of Law.

This particular case involves a loss on disposal of assets claimed by the Provider as a result of a statutory merger. The Provider began operations as a charitable hospital in 1925.[23] Prior to the merger, it was operated by Hermann Hospital Estate, a testamentary trust established under the will of George H. Hermann.[24] The Provider was part of the Texas Medical Center. As such, the Provider was subject to Texas Medical Center restrictions that prohibited use of the hospital for private gain or profit, and limited the use of the hospital property to health and educational purposes.[25] Prior to completion of the merger, a court proceeding was held to obtain authorization and approval of the transaction. The court entered a final judgment on October 3, 1997, approving and authorizing the merger.[26]

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[23] Transcript of Oral Hearing (Tr.) at 1, 50.
[24] Provider Exhibit P-9.
[25] Provider Exhibit P-39 at 19. The corporation was formed for the benevolent charitable and educational purposes and among other things to promote, assist establish support and maintain facilities for medical, dental, and nursing education and to promote provide or assist general health programs and to join with other institutions towards these ends.
[26] Provider's Exhibit P-9.

On November 4, 1997, the Provider consummated a statutory merger with Memorial Hospital System (MHS) a Texas not-for-profit corporation.[27] MHS, as the surviving legal entity, changed its corporate name to Memorial Hermann Hospital System (MHHS). MHS (now renamed MHHS) acquired all the assets and assumed the liabilities of the Provider.[28] The assumption of the Provider's liabilities was the sole monetary consideration for the transaction and estimated to be $373 million.[29]

Applying the statute, regulations, PRM and CMS policy to the facts of this case, the Administrator agrees with the Board's determination 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. The Board found that the Provider did not receive "reasonable compensation" for its assets, which is an element of a bona fide sale. In the *bona fide* sale, context, the reasonable consideration inquiry involves determining whether the provider received fair market value for its assets. In this case, the Board found that a large disparity existed between the value of the assets sold and the consideration (assumption of liabilities) received. The Board found that the consideration received by the Provider for its depreciable assets was zero.

The record shows that, in consideration for the transfer of the assets, the merged entity agreed to assume the Provider's liabilities of approximately $373 million.[30] The record shows that on October 31, 1997, the total net book value of the assets acquired from the Provider were approximately $755.5 million.[31] The Provider adjusted, downward, the net book value of total assets to approximately $490 million[32] and increased upward the consideration given (i.e., the assumption of debt) by $35 million as a result of a loss on bond refinancing. As a result of these various adjustments to total assets and increases in liabilities, the Provider argued that the record shows that consideration received by the Provider was well within the fair market value range. The Provider argued that these adjustments show, among other things, that the value of the hospital as a "going concern" was significantly less than the net book value and, when compared to the liabilities, demonstrated that reasonable consideration was given for the transfer of the depreciable assets.

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[27] Provider Exhibit P-8.
[28] Provider Exhibit P-8.
[29] Intermediary Exhibit I-3 at 8.
[30] Provider Exhibit P-48, Ex. 4, at 1.
[31] Provider's Exhibits P-10 (Intermediary workpapers at p. 8) and P-4.
[32] The Provider's adjustments included adjusting downward the building and equipment value by $77 million for unused capacity. In addition, the Provider claimed that the total non depreciable assets should be reduced by approximately $188 million of the #331 million for the "Limited Use Assets."

The Provider's attempt to derive a fair market value of the Hospital based on its own attempts to capture the value as a going concern, in lieu of a cost approach appraisal, does not conform to Medicare requirements.[33] First, the Administrator finds that the reproduction (replacement) cost approach is the only appraisal methodology that assigns a value to each individual asset and thus the only approach that is acceptable when an appraisal is used to assign value to the depreciable assets. A valuation based on a hospital as a going concern is not appropriate under Medicare depreciation rules. However, in light of the fact no appraisal was conducted in this case, the Board reasonably concluded that the use of the net book value of the assets was appropriate. In arriving at this conclusion, the Board noted, among other things, that there was evidence that the owner's treatment of the assets for financial reporting purposes indicated that it did not perceive the fair market value to be materially less than the net book value (e.g., no recording of impairments) and that there was a lack of direct evidence as to fair market value.

As stated above, "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 this case the Administrator finds that a large disparity existed between the sale price and the fair market value of the assets sold. The record shows that the consideration received by the Provider was assumed liabilities of approximately $373 million.[34] The record shows that on October 31, 1997, the total assets acquired from the Provider were approximately $755.5 million.[35] This included total current assets of $141 million, total non-current assets whose "use is limited-investments" of $331 million; and "PPE" (property, plant and equipment) of $252 million.[36] The merged entity in turn assumed the approximately $373 million of liabilities. Thus, regardless of the determined fair market value of the depreciable assets, the record shows that the liabilities assumed were approximately equal to the value of the current and noncurrent (non-depreciable) assets. Hence, in essence, the depreciable assets

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[33] The Administrator also finds that the loss due to bond refinancing was not part of the transaction and should not be used to increase the "consideration." Regardless, such a cost would be amortized. *Shalala v. Guernsey Memorial Hospital*, 115 S. Ct. 1232 (1995). Further, there is no accounting or Medicare policy support for devaluing the dollar worth of the limited use funds under the facts of this case as even recognized by the Provider's "Expert Report." Provider Exhibit 48.

[34] Provider Exhibit P-48, Ex. 4, at 1.

[35] See, e.g., Provider Post Hearing Brief at 48.

[36] While not determinative in this case of the $252 million for depreciable assets, the Board removed the value assessed for "construction in progress." However, such a removal is not supported by Medicare policy.

were transferred for no consideration."[37] Therefore, the Administrator finds that the transaction did not result in a *bona fide* sale for reasonable consideration.

In addition, while the Provider argued that the "consideration" was arrived at through arm's length negotiations, including a search for a suitable "buyer", the Administrator finds that Medicare does not reimburse providers for artificial losses generated through a provider's furtherance of a non-economic agenda. Rather, Medicare reimburses for actual losses that result from arms length bargaining. In this case, the Provider points to evidence of negotiations over the consideration given for the transfer of the assets. However, the evidence shows that the Provider's primary concern for the merger was to further the Trustees' mission "of continuing the maintenance and operation of Herman Hospital into the future as a hospital for the benefit of the poor indigent and infirmed residents of the City of Houston…" and that the Trustees, in furtherance of their fiduciary duties and diligence "researched various courses of action designed to ensure the future viability of Hermann Hospital."[38] In addition, the parties' failure to procure an appraisal is also evidence that the negotiations were not about obtaining the fair market value of the assets. In sum, the record shows that the Trustees' conduct and negotiations were to ensure the post-merger existence of the Hospital consistent with the Trustees' mission and that this was paramount to the detriment of arriving at the best price for the sale of the depreciable assets. That is, the record shows that the Trustees' interests were inseparable from the interests of the post-merged provider. Such conduct is in stark contrast to the definition of an arms' length transaction which "is a transaction negotiated by unrelated parties, each acting in its own self interest in which objective value is defined after selfish bargaining." Consequently, the Administrator concurs with the Board's determination that the Provider is not entitled to reimbursement for a loss on disposal of assets because the Provider failed to demonstrate that the merger was a *bona fide* sale.

However, the Administrator does not agree with the Board's determination that the regulation bars the application of the related party principle to the merging parties' relationship to the surviving entity. The Board concluded that the related party concept only applied to the entities relationship that existed prior to the merger and in the alternative, even if it did, the facts do not support such a conclusion in this case. The Administrator holds that the related party principle applies to the parties' relationship pre

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[37] As noted, a donation is defined in §413.134(b)(8) and 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. Consequently, even if the parties were found not to be related, the transaction here can be determined to have occurred without making any payment and hence was a donation of the depreciable assets for which no gain or loss is allowed.

[38] Provider Exhibit P-9 at 6-8.

and post merger. The Administrator finds that the related party organization was previously explained in HCFA Ruling 80-4 which adopted the Eight Circuit Court of Appeals decision in *Medical Center of Independence v. Harris*.[39] The Court in Harris 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. *Harris* asserted that the applicability of the related party rule is also determined by considering the relationship between the parties according to their subsequent 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. The Administrator finds that relevant to the consideration of the related party principle is the analysis as to whether the parties were related prior to and after the merger. This is also most obviously seen in a reorganization of one entity and is also present in a merger or consolidation of several hospitals.

In this instance, applying the related party principle, the record, for example, shows that of the twelve board directors on the merged entity's board, five were appointed by MHC and five were appointed by the Provider/Trustees. The five board members appointed by the Provider were *ex officio* members of the Provider's former health system board and the President and Chief Operating Officer of the former health system. Moreover, as noted above, the record shows that the conduct of the Provider's Trustees demonstrated that their interests were inseparable from the interests of the post-merged provider.[40] In addition, the financial report of the merged entity shows that the transaction was treated as a "pooling of interest" business combination,[41] which is considered a continuation of business interest. Consequently, based on the record, the Administrator finds that the transaction was between related parties as the merged entity reflected the Provider's continuity of interest and control in the merged entity.

[39] 628 F.2d 1113 (8 th Cir. 1980).
[40] In addition, the Trust did not cease to exist but rather continued to have as its assets a revisionary interest in the assets as described in the Will of the testator.
[41] Intermediary Exhibit I-8 at 5.

DECISION

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

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

Date: 5/23/11 /s/

Marilyn Tavenner
Principal Deputy Administrator and Chief Operating Office
Centers for Medicare & Medicaid Services