CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Iowa Lutheran Hospital **Provider** **vs.** **BlueCross/ BlueShield Association/ Cahaba Government Benefits Administrator** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Year Ending: 11/21/93** **Review of: PRRB Dec. No. 2007-D1 Dated: October 6, 2006**

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. Comments were also received from the Provider requesting affirmation of the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

Iowa Lutheran Hospital (Provider) was a general, acute care, not-for-profit hospital located in Des Moines, Iowa. Effective November 22, 1993, the Provider merged with Iowa Methodist Medical Center (Iowa Methodist) pursuant to the laws of the State of Iowa. Iowa Methodist was the surviving corporation and continued to operate as a not-for-profit entity. The Provider submitted a terminating Medicare

cost report for the period ended November 21, 1993 to its fiscal Intermediary.[1] Based on the regulatory provisions of 42 C.F.R. §413.134 et seq., the Provider claimed a loss on the disposal of its assets resulting from the statutory merger. Upon audit of the cost report, the Intermediary disallowed the claimed loss on the basis that the merger was a transaction between related parties, pursuant to 42 C.F.R §413.17 et seq. The Provider appealed the Intermediary's disallowance to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The estimated amount of Medicare reimbursement in controversy is approximately $5,400,000.[2]

ISSUE AND BOARD'S DECISIONS

The issue is whether the Intermediary's adjustments to the Medicare cost report that disallowed the loss on disposal depreciable assets resulting from a merger were proper.

The Board held that the Provider is entitled to claim a loss on disposal as a result of the statutory merger of the Provider and Iowa Methodist, and stated that a revaluation of the assets and a recognition of the loss incurred as a result of the merger is required under the specific and plain meaning of 42 C.F.R. §413.134(1)(2)(i). The Board addressed the two fundamental arguments offered by the Intermediary in its denial of the Provider's claim. First, the Board stated that contrary to the Intermediary's arguments, the merger was not between related parties and thus, the regulation at 42 CFR §413.134(k)(2)(1) allows the assets of the merged corporations acquired by the surviving corporation to be revalued.

The Board rejected the Intermediary's assertion that the because the board of directors of the new entity was substantially composed of board members of the two merging entities, there was a "continuity of control" that resulted in the parties being related. The Board concluded that the plain language of 42 C.F.R. §413.134(1)(2)(iii) barred application of the related party principle to the merging parties' relationship to the surviving entity. The Board concluded that the regulation only the relationship of the parties participating in the merger before it was completed is relevant to whether the assets would be revalued and a gain or loss recognized. Furthermore, the Secretary's interpretive guidelines found at HCFA Pub. 13-4 §4502.6, which stated in part: "Medicare program policy permits a revaluation

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[1] In June 2000, Cahaba Government Benefits Administrators assumed Wellmark Blue Cross and Blue Shield's fiscal intermediary duties.

[2] Provider's Post-Hearing Brief at Exhibit P-43.

of assets affected by corporate mergers between unrelated parties" only helped to support the Board's determination.

The Board also found that because there is a specific regulation that controls the recognition of a loss on the merger transaction in this case, 42 CFR §413.134(1), the merger is not required to meet bona fides of sales transactions addressed in 42 CFR § 413.134(f)(2). The Board observed that while it is aware that the regulation on mergers may be interpreted as applying to stock transactions, the Agency interprets the regulation to apply to non-profit transactions as well.

The Board acknowledges that there was no "disposition" of assets as that term is used in the regulation on gains and losses and that the Providers, through merger under a new corporate structure, continued to provide substantially the same services using essentially the same facilities and personnel. However, given the regulation's explicit limitation on the application of the related party principle and the Agency's longstanding interpretation that the regulation applies to non-stock company transactions, the Board found no authority in the regulation or guidelines in effect at the time of the transaction to permit motivations unique to non-profits to be a determining factor in the reimbursement treatment.

The Board found that the completed transaction merged one independent hospital corporation, the Provider, into another hospital corporation, with the merged entity ceasing to exist. The Board found, contrary to the Intermediary's "continuity of control" assertions, that such an interpretation of the related party regulation is not only inconsistent with the regulation governing statutory mergers, but in direct opposition to the purpose of corporate mergers. The Board reasoned that the very nature of a statutory merger as a combination of entities would likely result in some overlap of membership on the board of directors of the merging corporation and the surviving entity, as well as a continuation of other operations and personnel of the merging organization. The Board concluded that the fact that this occurs does not disqualify a statutory merger from revaluation and recognition of any gain or loss under 42 C.F.R. §413.134(1).

Finally, the Board found that the calculation of the loss should be based on the proportionate value method set forth in 42 C.F.R. §413.134(f) (2) (iv). The Board noted that a discrepancy between the fair market value of the assets described in Provider's Exhibit P-43, and P-41,[3] which must be resolved in order to accurately

[3] Exhibit P-43 was submitted with the Provider's Post-Hearing Brief of $64,949,110 and the amount shown in Exhibit P-41 of $62,700,000, which is the Business Evaluation of the Provider's operation conducted by KPMG Peat Marwick.

determine the Provider's reimbursable loss. The Board also found that the merger results in the Provider's assets being valued at amounts significantly less than their book value, resulting in a loss. However, the Board observed that for accounting purposes the merger was treated as a pooling of interests and the carrying value of the Provider's assets was not recorded in the financial records of the surviving entity at their written down values. The Board stated that for areas of the surviving entity that continued to be reimbursed under Medicare's reasonable cost principles, the amount of depreciation allowed by the Medicare program during the years following the merger has been overstated. As a result, the Board maintained that the allowable loss must be adjusted (reduced) to account for this overstatement.

SUMMARY OF COMMENTS

Intermediary Comments

The Intermediary submitted comments requesting that the Administrator reverse the Board's decision. The Intermediary argued that the transaction cannot be placed under 413.134(f) as a disposal of assets which would result in a depreciation corrective adjustment since there was no "bona fide sale." The Intermediary stated that the Administrator has recognized the exchange as between related parties in that the claimant was a partner to the creation of the product of the affiliation and the recipient of the assets and liabilities.[4]

CMM Comments

CMM commented requesting that the Administrator reverse the Board's decision. CMM argued that the Board made several errors in its decision. First, the Board incorrectly found that, pursuant to 42 C.F.R §413.134(1)(2), the Intermediary could only examine whether the parties to the merger were related prior to the merger transaction. Consequently, the Board rejected the Intermediary's argument that there was a continuity of control that resulted in the parties to the merger being related. CMM believes that 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 to have incentives to see above or below fair market value. CMM argued that the Intermediary correctly contended that the merger was a related party transaction pursuant to 42 C.F.R §413.17, since the provider has the power to significantly influence or direct the actions and policies of Iowa Methodist, the surviving corporation. CMM noted that after the merger, directors affiliated with the Provider

[4] The Intermediary cited examples of the proper analysis,, referring to *St. Joseph Medical Center*, 2002-D64 and *Robert F. Kennedy Medical Center*, 2005-D9.

comprised a near majority of both the surviving corporation and that of the surviving corporation's sole member. CMM argued that the significant representation the Provider had on both boards was sufficient justification for the Intermediary to disallow the claimed loss-on-sale under the related party doctrine.

CMM commented that the courts that have addressed the issue have deferred to CMS's reasonable interpretation that 42 C.F.R. §413.134(1)(2) must be read together with 42 C.F.R. §413.17 and that the related party doctrine applies to relationships created by the transaction at issue as well as preexisting relationships.[5] CMM argued that an important factor is whether the composition of the new board of directors at the surviving corporation includes significant representation from the Provider's previous board or management team. CMM noted that eight members of the surviving corporation's board of directors had served previously on the Provider's governing board, the Provider maintained a financial interest in the surviving corporation's assets through calendar year 2000 should Iowa Methodist disperse, and the Provider's president became the executive vice-president of the surviving corporation.

Second, CMM argued that the Board erred in finding that the merger was not subject to the bona fide sale requirement. There is no indication in the regulations that the bona fide sale requirement is not applicable to mergers and consolidations. In this case, the transfer of assets from the merged provider corporation was not a bona fide, arms-length transaction between two non-related parties. There was never a bargaining or an attempt of maximizing fair market value of the purchase price being negotiated in an open market buyer/seller approach. The PRRB found that the Provider transferred assets with a fair market value in excess of $62 million, including $41 million in cash for the assumption of approximately $26 million in liabilities. CMM maintained that the transaction was not a bona fide sale, and that the Intermediary's disallowance should be upheld.

Provider Comments

The Provider commented that the Board correctly determined that the Intermediary's disallowance of Iowa Lutheran Hospital's loss on statutory merger was contrary to regulatory requirements. Provider argued that Iowa Lutheran Hospital correctly determined the amount of loss incurred on the statutory merger, and that there were no discrepancies that require a remand to the Intermediary for recalculation of the claimed loss. The Provider also argued that the Board impermissibly required the Intermediary to disallow depreciation costs related to Medicare cost years that were

[5] Program Memorandum (PM) A-00-76 clarifies how 42 C.F.R. §413.134(1) applies to mergers involving non-profit providers.

not before the Board. In doing so, the Board impermissibly interjected a new issue that was not part of the appeal, improperly reduced the amount in controversy, violated applicable statutory and regulatory requirements, and deprived the surviving entity to various rights provided under the Secretary's regulations addressing "reopening" of cost report determinations.

The Provider further cited three reasons as to why the Board's decision effectively reversing each Intermediary determination reimbursing the surviving entity for depreciation costs based on Iowa Lutheran Hospital's carrying value was impermissible. First, in determining Medicare reimbursement due to a Provider, Medicare statutory and regulatory principles consider each cost reporting period separate and distinct from others. There is no mechanism to permit reduction of a Provider's allowable cost for one cost reporting period based on cost reporting determinations that relate to subsequent Medicare cost reporting periods. Second, under the governing statute, the Board does not have jurisdiction to make determinations regarding costs covered by cost reports that are not before the Board, particularly in this matter, depreciation costs recognized by Medicare in periods subsequent to the cost reporting period over which the Board has jurisdiction. Third, the Secretary's regulations require revisions of settled cost reports to be made in accordance with "reopening" regulations.[6]

The Provider concluded that the Administrator should require reimbursement of the loss Iowa Lutheran Hospital incurred on statutory merger as calculated by the provider. The Intermediary may recover any overstated depreciation paid to the surviving entity in subsequent cost reporting periods only in accordance with the Secretary's reopening regulations.

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

[6] *See* 42 C.F.R §405.1889.

actually incurred, excluding there from any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The Act further authorizes the Secretary to promulgate regulations establishing the methods to be used and the items to be included in determining such costs. Consistent with the statute, the regulation at 42 CFR §413.9 states that all payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries.

A. Capital Related Costs.

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

Title VI of the Social Security Amendments of 1983[7] added §1886(d) to the Act and established the prospective payment system (PPS) for reimbursement of inpatient hospital services provided to Medicare beneficiaries. Under this system, hospitals are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge according to a list of diagnosis-related groups. Reimbursement under the prospective payment rate is limited to inpatient operating costs. The Social Security Amendments of 1983[8] amended subsection (a)(4) of §1886 of the Act to add a last sentence, which specifies that the term "operating costs of inpatient hospital services", does not include "capital-related costs (as defined by the Secretary for periods before October 1, 1986)...." That provision was subsequently amended until finally, §4006(b) of OBRA 1987 revised §1886(g)(1) of the Act to require the Secretary to establish a prospective payment system for the capital-related costs of PPS hospitals for cost reporting periods beginning in fiscal year (FY) 1992.

1. Depreciation.

For cost years prior to the implementation of capital PPS, pursuant to the reasonable cost provision of §1861(v)(1)(A) of the Act, the Secretary promulgated regulations on the payment of capital costs, including depreciation Generally, the payment of depreciation is based on the valuation of the depreciable assets used for rendering

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

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.[9]

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

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

The regulation at 42 CFR §413.130 explains, inter alia, that:

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

The regulation specifies that only certain events will result in the recognition of a gain or loss in the disposal of depreciable assets. The Secretary explained in

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

proposed amendments to the regulation clarifying and expanding existing policy on the recognition of gains and losses, in 1976, that:

> The revision would describe the various types of disposal recognized under the Medicare program, and would provide for the proper computation and treatment of gains and losses in determining reasonable costs.[10]

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

> Existing regulations contain a requirement that any gain or loss realized on the disposal of a depreciable asset must be included in Medicare allowable costs computations ... The regulations, however, specify neither the procedures for computation of the gain or loss nor the methods for making adjustment to depreciation. These amendments provide the rules for the treatment of gain or loss depending upon the manner of disposition of the assets.[11] (Emphasis added.)

These rules have been set forth at 42 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 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.)

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

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

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

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

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

> A bona fide sale contemplates an arm's length transaction between a willing and well informed buyer and seller, neither being under coercion, for reasonable consideration. An arm's length transaction is ... negotiated by unrelated parties, each acting in its own self interest.[12]

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[13] of the asset stating that: "[g]ains or losses realized from the

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

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

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

This latter issue, on the revaluation of assets, was the subject of significant litigation for the Medicare program regarding complex transaction and resulted in agency rulemaking on the subject. In response to litigation, the regulations at 42 CFR §413.134(k)(1991).[15] were promulgated to address longstanding Medicare policy regarding depreciable assets exchanged for capital stock, statutory mergers and consolidation. Concerning the valuation of assets, the regulation states that:

> (1) 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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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.

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

[15] (1995) Originally codified at 42 CFR §405.415(1).

(i) Statutory merger between unrelated parties. If the statutory merger 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

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).[16]

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

> The owners of a 200-bed hospital convert their facility to a nonprofit corporation. The owners sell the hospital to a non-profit corporation 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.

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

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).[17] 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. Interaction of the Various Regulationa on 42 CFR 413.134(k)

The Administrator also notes that the Board also made several findings regarding the interaction of the various regulations on 42 CFR §413.134(k).[18] However, the

[17] 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.

[18] While not dispositive to this case, the Board concluded that the CMS policy on consolidation revaluations in the final rule published Feb 5, 1979 was a change from the proposed rule published in April 1, 1977. However, the final rule would appear to contradict that conclusion. The final rule states that it does not differ in substance from the proposed rule (44 Fed Reg. 6913) and it was made effective on the date published, an act consistent with that statement. An immediate effective date for any substantive change would have required a good cause exception under the APA published in the final rule. The final rule also stresses that the policy that the rule clarifies on the revaluation of assets is longstanding policy Medicare policy and does not note any changes on consolidations as a result of comments. The change referenced from the proposed rule is that the final rule dedicates separate paragraphs to related and unrelated transactions involving consolidations, similar to that provided

Administrator finds that, as the issue under appeal involves the recognition of depreciation losses on the transfers of assets from a consolidation between non-profit entities, he cannot limit his review to the specific consolidation requirement of 42 CFR §412.134(k). Paragraph (k) 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 (k) did not modify or limit the general related party rules at §413.17 and does not address or modify the criteria for the recognization of gains or losses at paragraph §413.134(f). Instead, the Secretary explicitly stated that this provision was being promulgated consistent with both the related party rules and the disposal of depreciable asset rules set forth at paragraph (f).[19]

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for statutory mergers. Thus, based on the foregoing, one could conclude that this change was to clarify the proposed language, rather than to promulgate a substantive change from the proposed rule.

[19] See, e.g., 44 Fed. Reg. 6912 (Feb 5, 1979)("Although no single provision of the Medicare regulations explicitly set forth these policies, our position has been based on the interaction of three regulations*:* 42 CFR 405.415, concerning the allowance for depreciation based on asset costs; 42 CFR 405.427, concerning cost related organizations; and 42 CFR 405.626, concerning change of ownership. We continue to believe that our interpretation and application of these regulations are reasonable and consistent with our statutory mandate to determine the scope of the reasonable costs for Medicare providers." (Emphasis added.)); 42 Fed. Reg. 6912 ("Our intent is not to change existing Medicare policy, but merely to state explicitly in the Code of Federal Regulations that which has been stated in the past in less formal settings."); 42 Fed. Reg. 17486(1977)("The proposed revision of paragraph (1) of 405.415 is also consistent with paragraph (f). When a provider's assets are sold the transaction causes adjustments to the seller's health insurance program allowance for the depreciation based upon the gain or loss on the sale of the asset. Because a sale of corporate stock is not a sale of the corporate assets, the provisions of paragraph (f) of 405.415 are not applicable to the seller after such a transaction."); 44 Fed. Reg. 6913 ("Only if the assets are transferred by means of a bona fide transaction between unrelated parties would revaluation be proper.")

D. 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(1) to non-profit providers with respect to the related party rules and the rules on the disposal of depreciable assets, CMS issued Program Memorandum (PM) A-00-76, dated October 19, 2000. This PM applies the foregoing regulations to the situation of non-profit corporations. In particular, this PM noted that non-profits differ in significant ways from for-profit organizations. Non-profit organizations typically do not have equity interests (i.e. shareholders, partners), exist for reasons other then to provide goods and services for a profit, and may obtain significant resources from donors who do not expect to receive monetary repayment of or return on the resources they provide. These differences, among others, cause non-profit organizations to associate or affiliate through mergers or consolidations for reasons that may differ from the traditional for-profit merger or consolidations. In contrast, the regulations at 42 C.F.R. §413.134(1) 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(1) and as defined in the PRM at §104.24. The PM stated that the regulation at 42 C.F.R. §413.134(1) 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.[20] 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

[20] 42 Fed. Reg. 45897 (1977).

before and after the termination.[21] Thus, the PM interpretation of the related party rules as requiring an examination of the relationship before and after the transfer of assets is consistent with early Medicare policy and HCFAR 80-4.

This interpretation, that "between related organizations" must include an examination of all parties to the transaction, both before and after, is also consistent with the reality of a transaction involving the merging of two or more entities. For example:

> Corporation A and Corporation B, both non-profit providers, are combined by statutory merger with Corporation A surviving. Corporations A and B were unrelated prior to the transaction, each being controlled by its respective Board of ten Directors. After the merger, Corporation A's new ten member Board of Directors includes five individuals that served on Corporation B's pre-merger board. Thus, Corporation A's new Board of Directors includes a significant number of individual from both of the former entities' boards. Because no significant change of control of the assets of former Corporation B has occurred, the transaction as between Corporation A and Corporation B is deemed to be between related parties and no gain or loss will be recognized as a result of the transaction. Hence, Medicare reasonably examines the relationship between the merging corporations and the surviving corporation and recipient of the Medicare depreciable assets to determine whether the transfer involved a related party transaction.[22]

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

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[21] 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.)

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

organizational structures and included as one possible type of provider organization are Corporations.

In defining a Corporation, §4502.1 explains that a corporation is a legal entity, which enjoys the rights, privileges and responsibilities of an individual under the law. An interest in a corporation is represented by shares of stock in proprietary situations (stockholders) or membership certificates in non-stock entities (members).

Among the various types of provider structures and transactions recognized by Medicare are mergers, consolidations, and corporate reorganizations at §4502. Section 4502. 6, describes a statutory merger as the combination of two or more corporations pursuant to the laws of the state involved, with one of the corporations surviving the transaction. Medicare program policy permits a revaluation of assets acquired in a statutory merger between unrelated parties, when the surviving corporation is a provider. Notably, Medicare policy at §4502.10 does not permit a revaluation of assets affected by a "reorganization" of a corporate structure. All such transactions are considered among or between related parties. As an example the Intermediary Manual explains that:

> Provider A is organized as a nonprofit corporation. The assets of Provider A are reorganized under state law into a newly created proprietary corporation. The transaction constitutes a related party transaction (i.e. corporate reorganization). As the transaction was among related organizations no gain/loss is allowed for the seller and no revaluation is allowed for the buyer.

In the instance of a re-organization, CMS examines, inter alia, the parties before and after the transaction in determining that the transfer of assets involved a related party transaction.

Section 4508.11 of the Intermediary Manual,[23] 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

[23] 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."

from that set forth in GAAP,[24] Intermediaries are instructed to refer to the principles outlined in the CHOW manual which specify when reference to APB No. 16 is in accordance with the current Medicare policy.

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

E. 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.[25] 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

[24] 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).

[25] 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).

has often explicitly stated when such Medicare policy agrees or diverges from IRS treatment.[26]

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.[27] 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.[28] (Emphasis added.)

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[26] 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).

[27] 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.")

[28] 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

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."[29] 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."[30]

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.

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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. C1. 585 (1954).

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

[30] 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)).

Consequently, one purpose of the IRS policy is to prevent the claiming of a gain or loss when no such event has in fact occurred. Similarly, the related party rules under Medicare, in holding that there is no recognition of a gain or loss when there is a reorganization, consolidation or merger between related parties, is to avoid the payment of costs not actually incurred by the parties. An overarching principle applicable under the Medicare statute and regulation, with which all reasonable cost regulations must be in accord, is the principle that Medicare will only share in costs actually incurred by the provider. Consistent with IRS rules, which recognize that no cost has been incurred under the foregoing facts, Medicare similarly does not find that the provider has incurred an actual cost for purposes of Medicare reimbursement under such facts.

II. Finding of Facts and Conclusion of Law.

This particular case involves the Provider's claim for a loss on the disposal of assets as a result of a merger. The transaction involved the Iowa Lutheran Hospital (Provider) and the Iowa Methodist Medical Center (the surviving corporation)(Iowa Methodist.) Prior to the merger, the Provider was a general, acute care, not-for-profit hospital located in Des Moines, Iowa. The Provider was incorporated, inter alia, for the purpose of establishing, equipping operating and maintaining a "benevolent and charitable Christian institution for the providing of medical, surgical, and hospital care." (Provider Exhibit P-35.) The sole member of the corporation was the Southwest Iowa Synod of the evangelical Lutheran Church in America. (Provider Exhibit P-36)

In February of 1993, the Provider and Iowa Methodist executed a non-binding Memorandum of Understanding that set forth their intention to combine and the anticipated benefits to be derived from their combination. A purpose of the combination was to develop, improved and lower health care costs for the communities served by the two hospitals through, inter alia, the integration of complimentary heath care delivery systems, operational efficiencies and reduced operating costs, increased responsiveness to changes in health care delivery, and achieving critical mass necessary to maximize service quality while minimizing costs. The Memorandum of Understanding anticipated that, after the combination Iowa Health System would be the sole member of Iowa Health System Corporation (formerly Iowa Methodist Medical Center) the surviving corporation. Iowa Health System would have no member. In addition, the final legal structure would be under review and would take into account applicable reimbursement rules and regulations. The memorandum of understanding included the composition for the sole member's board of directors, executive officers, and the governing documents of the sole member including the provision for distribution of its assets to the Southwestern

Iowa Synod of the ELCA in accordance with a schedule based on the calendar year of the dissolution.[31]

On November 22, 1993, the Provider merged into Iowa Methodist following the simultaneous signing of a Formation Agreement and the filing of the Articles of Merger with the State.[32] The sole member of Iowa Methodist, after the combination, was Iowa Health System. The Restated Articles of Incorporation of Iowa Health System were also made effective November 22, 1993. Iowa Methodist was renamed Iowa Health System Hospital Corporation.[33] The Restated Articles of Incorporation of Iowa Health System Hospital Corporation were made effective November 22, 1993. (P-3) By operation of the law, the existing assets and liabilities of the Provider were acquired and assumed by the surviving corporation Iowa Health System Hospital Corporation.

The governing documents provided the names "Iowa Methodist Medical Center" and "Iowa Lutheran Hospital" would continue to be used for the present campuses until at least the year 2000 unless otherwise agreed by the Southeastern Iowa Synod of the Evangelical Lutheran Church in America with respect to the Provider, and by the Iowa Annual Conference of the United Methodist Church with respect to Iowa Methodist.[34] The surviving corporation was organized exclusively for charitable, religious, scientific, and educational purposes.[35]

After the merger, the Agreement provided that the governing board for Iowa Health System, the sole member of the surviving corporation, would consist of a total of twenty-three members.[36] Specifically, the initial Board of Directors of the sole member, Iowa Health System, would consist of: eight directors selected by the current Board of Directors of Iowa Methodist Health System, seven directors selected by the current Board of Directors of the Provider. In addition, the board of directors would be comprised of the President and the Executive Vice President of the sole

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[31] This provision in the Memorandum of Understanding was adopted in the Iowa Health System Articles of Incorporation. P-3 at p 4.

[32] Provider Exhibit P-2, Articles of Merger I(a), in pertinent part, "Iowa Lutheran Hospital ... shall merge into Iowa Health System Hospital.... And Iowa Health System Hospital Corporation shall be the surviving corporation."

[33] Provider Exhibit P-1.

[34] *Id.*

[35] Provider Exhibits P-2, Restatement of Articles of Incorporation for Iowa Health System.

[36] Provider Exhibit P-2 Restated Articles of Incorporation of Iowa health System

member,[37] two physicians selected by the current Iowa Methodist Health System Board, two physicians selected by the Provider's current Board, the Bishop of the Southeastern Iowa Synod of the Evangelical Lutheran Church in America (sole member of the Provider), and the Bishop of the Iowa Annual Conference of the United Methodist Church.[38]

The Agreement provided that the Bishop of the Iowa Annual Conference of the United Methodist Church, or a person designated by the Bishop, shall be an ex officio member of the Board of Directors, with vote, so long as the word "Methodist" is used by the Corporation or by any other corporation in which the Corporation is a member or stockholder with majority interest. The Bishop of the Southeastern Iowa Synod of the Evangelical Lutheran Church in America, or a person designated by him, shall be an ex officio member of the Board of Directors, with vote, so long as the word "Lutheran" is used by the Corporation or by any other corporation in which the Corporation is a member or stockholder with majority interest.[39] The Agreement also provided that unless otherwise directed by the board of directors, gifts and bequests to the Iowa Methodist would be forwarded to Iowa Methodist Health Foundation and gifts and bequests to Iowa Lutheran Hospital would be forwarded to Iowa Lutheran Hospital Foundation.[40]

Applying the statute, regulations, PRM, and CMS policy to the facts of this case, the Administrator finds that based on a combination of factors the parties to the merger are related through control. In applying the related party principles at 42 C.F.R. § 413.17, the Administrator finds that consideration must be given as to whether the composition of the new board of directors at the surviving corporation included significant representation from the Provider's previous board or management team. This involves determining whether former board members of the Provider had the power, to directly or indirectly, influence or direct the actions or policies of the surviving corporation. If such is the case, then no real change of control of assets has occurred and no gain or loss will be recognized as a result of this transaction. As

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[37] The President and Vice President of the sole member are, respectively, the President of Iowa Methodist and President of Iowa Lutheran.

[38] Provider Exhibits P-2, Memorandum of Understanding. The board of director for the surviving corporation was similarly structured but with 19 board members. The composition was the same except for the exclusion of the two respective clergy and one board member chosen by the Provider and one board member chosen by the Iowa Methodist. See Provider Exhibit P-3, "Restated Articles of Incorporation of Iowa Health System Hospital"; Transcript of Oral Hearing at 127.

[39] Provider Exhibits P-3, Restated Articles of Incorporation of Iowa Health System.

[40] Provider Exhibit P-2, Formation Agreement.

stated above, the term "control" includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised.

In this case, the record shows that seven members of the Board were to be selected by the Provider's board of directors, that the Provider was to select two of the physicians for the board; that the former president of the Provider (as the current vice president of the sole member) and the Bishop of the religious affiliation of the Provider were to serve on the board. This membership comprised approximately 48 percent of the voting positions in the surviving entity's board of directors.[41] Moreover, the Chairman and President of the Provider, went on to accept positions as Vice Chairman of the Board and Executive Vice President, respectively, of the sole member of the surviving corporation.[42] In addition, the Vice chairman was is to be given first consideration upon the retirement of the chairman of the board or a person from the Provider is to be selected. This carry forward of top executives and board members from the Provider to the surviving corporation/sole member assured the continuing influence and control of the Provider in the surviving corporation and its sole member.

The Administrator finds that the common former board members and officers enabled the Provider to significantly influence or direct the actions or policies of the surviving corporation/sole member and showed a continuity of control between the Provider and the surviving corporation/sole member. A provider may not claim a loss on depreciation if the sale was between related parties. Thus, based on the totality of the circumstances, the Administrator finds that the Provider is related through continuity of control with the surviving corporation, and not entitled to a loss.

The Administrator finds that the rationale for finding that this entire transaction constitutes a related party transaction under the Medicare policy is supported by the record. An overarching principle of Medicare reimbursement, which serves as the basis for the prophylactic related party rule, is that the costs actually incurred are reimbursable under Medicare. Thus, it is reasonable to find in this case, the Provider's interests have been but recast in a different form only and thus a loss has not actually been incurred by the Provider that can be recognized by Medicare under §1861 (v)(1)(a) of the Act.

The Administrator finds the common criteria between the IRS rules and the Medicare rules is that a transaction is treated similar to, or as, a reorganization (in that no gain or loss is recognized), regardless of the transaction title, when there is a continuity of interest or control between the merged corporation and the surviving corporation.

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[41] Provider Exhibit P-2.
[42] Provider Exhibit P-2.

That is continuity of interest or control, is evidence that the entity has but recast its interest in another form and no actual loss has been incurred.

In addition, the reasonable cost rules are properly interpreted consistent with the economic reality of this transaction. Notably, the merger was treated as a pooling of interests.[43] The APB No 16, similar to the PM, recognizes and treats 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. The evidence indicating that the merger transaction was treated as a pooling of interest again shows that no actual loss was incurred by the Provider in which Medicare should share.

Since the parties to this transaction are found to be related, the Administrator finds that the transaction was not consummated through an arm's length transaction. 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 required. A large disparity between the sale price (consideration) and the fair market value of the assets sold indicates the lack of reasonable consideration and, hence, the lack of a *bona fide* sale. Examples of transactions that raise the issue of a bon fide sale are set forth in PM A-00-76:

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

The PMA-00-76 further states that:

> Non-monetary consideration, such as a seller's concession from a buyer that the buyer must continue to provide care for a period of time or to provide care to the indigent, may not be taken into account in evaluating the reasonableness of he overall consideration (even where

[43] *See* e.g. Intermediary Supplemental Position Paper at 23-24, Exhibits I-12, I-14.

> such elements may be quantified in dollar terms). These factors are more akin to goodwill than to considerations.

In this case, the record shows that assets were transferred from the Provider to Iowa Methodist for the assumption of liabilities totaling $28,092,831. The surviving corporation received $41,093,761 in cash plus all of the Provider's physical assets.[44] That is, the surviving corporation received cash/liquid assets of approximately $13 million and the value of physical assets which were in excess of the liabilities assumed. This does not on its face, in the Administrator's view, support a finding that the Provider transferred assets for reasonable consideration and as a result of a *bona fide* sale.[45] In the Administrator's view, the "transfer price", does not support a finding that the transaction was an arm's length transaction As set forth in the PRM at §104.24, reasonable consideration is a required element of a *bona fide* sale.

In addition, the fact that the parties did not secure an appraisal prior to the transaction is also an indication that the Provider was not concerned with receiving reasonable consideration for its depreciable assets.[46] The Provider also did not place its assets for sale in the open market to ascertain their worth established that there was no good faith bargaining between the parties to establish the fair market value of the Provider's assets as an ongoing concern. There is no documentation in the record to support a conclusion that the assumption of debt was fair consideration for the Provider's assets.[47] Instead a primary negotiation point was the composition of the board and executive officers and the Lutheran identity of the hospital; that is, the retention of control and power after the merger.[48] Thus, the Administrator finds that,

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[44] Intermediary's Position Paper at 8. Provider Exhibit 38.

[45] Even relying on the Provider Exhibit P-43 and P-41, the fair market value of assets is shown as $64,949,110 and $62,700,000, respectively, an amount far in excess of the liabilities assumed.

[46] See e.g. Provider Exhibit 41; KPMG Business Evaluation dated November 19, 1993.

[47] The record also does not show that the parties were engaged in arms length bargaining, reflective of a bona fide sale of the assets, over the potential Medicare loss on sale claim. The Medicare loss on sale claim, if the provider were to be successful, would be worth approximately $5.4 million in Medicare reimbursement which is not included in the $41 million in cash/liquid assets.

[48] See e.g. Transcript of Oral Hearing at 115 ("Q.... Could you maybe summarize.... the three key areas of negation ... A. In my recall, executive leadership, the transition, the future transition of executive leadership."); 116 (regarding the board members) and 198 ("The negotiations ... were generally amicable because the motivations of the board members were to do what was best for healthcare in Des Moines, but that there were some points that were, I think points of serious

as the transaction did not involve an arm's length transaction, 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 Administrator also finds that if the Provider's methodology is applied it means that the Provider transferred the depreciable assets for no consideration.[49] Without conceding this loss methodology, to find a bona fide sale there is a *logical* inconsistency which must be forced upon this transaction. That is, to find that any consideration was paid for the depreciable assets, a less than dollar-to-dollar allocation must be made to the monetary assets. When a dollar-to-dollar allocation is made to the current and monetary assets, the Provider in this case in fact disposed of the depreciable property for no consideration. In conclusion, the Administrator finds that this is not reasonable consideration required of an arms length transaction and bona fide sale. Thus, the transaction fails to meet the criteria required under 42 CFR §413.134(f) for a loss on the disposal of assets to be recognized.

As a loss cannot be allowed in this case, the Administrator does not reach the issue of how to calculate the loss. However, the issue of calculating a loss does point out certain anomalous results of finding that a loss is to be calculated in a case when there has been no bona fide sale. The Administrator concludes that this further supports a finding that no loss is to be calculated under these facts of this case.

Consequently, the Administrator finds that, not only was the transaction between related parties, but that there was no bona fide sale as required under 42 C.F.R. § 413.134(f).

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negotiation. Several were mentioned by Denny Drake. Certainly the role of the executive teams and the extent to which I would have a role in that system was a part of the negotiation. Probably the one thing that wasn't mentioned this morning and the assurance that was constantly sought and re-sought was the perpetuation of the Lutheran heritage and identity.....")

[49] See e.g. Provider Exhibit 38.1 showing allocation of no consideration for the depreciable assets. The Provider shows the depreciable assets with an approximate net book value of $12.9 million for building and improvements, $3.2 million for fixed equipment and $9.6 million for moveable equipment. In addition, the land asset is shown with a value of $1.7 million for which no consideration is allocated and, thus, under the Provider's analysis was transferred for no consideration. Of note, under section 4505.12 an asset is considered donated when it is acquired without the payment in the form of cash, property or services-including the assumption of liabilities. When provider depreciable assets are donated, there is no gain/loss allowed to the donor under the Medicare program.

DECISION

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

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

Date: **12/8/06** **/s/**

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