CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Cardinal Cushing Hospital **Goddard Memorial Hospital** **Provider** **vs.** **Blue Cross/Blue Shield Association** **Associated Hospital Services of Maine** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 09/30/94** **Review of:** **PRRB Dec. No. 2003-D19** **Dated: November 27, 2002**

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

BACKGROUND

By an amended and restated agreement dated September 7, 1993, Cardinal Cushing Hospital (Cushing) and Goddard Memorial Hospital (Goddard) entered

into a Consolidation Agreement.[1] Pursuant to the Consolidation Agreement, a new corporation, Good Samaritan Medical Center was formed.[2] The members of the nonprofit nonstock new corporation were Caritas Christi and Goddard Health Planning Corporation. The new Board of Trustees for Good Samaritan consisted of 24 members, 12 appointed by Cushing and 12 appointed by Goddard the constituent corporations. The new trustees who were specified in the consolidation agreement consisted of 21 members who had been member of the Goddard or Cushing Board's prior to the transaction and three community representatives who had not been members of either Board. The Chairman and Vice Chairman were to be appointed by the constituent corporations prior to the effective date, while the President was to be appointed by the "initial Board of Trustees, subject to approval by the members", and the Treasurer was to be appointed by the "initial Board of Trustees". A certificate of consolidation was filed with the State on October 1, 1993, with the effective date of the consolidation stated as 12:01 October 1, 1993.[3]

Good Samaritan acquired the assets of Cushing in exchange for the assumption of Cushing's debts and liabilities and simultaneously acquired the assets of Goddard in exchange for the assumption of Goddard's debts and liabilities. The total of the debts and liabilities assumed by Good Samaritan was $83,075,459. Prior to the consolidation, the book value of Cushing's total property, plant and equipment, net of depreciation, was $15,990,554. After the consolidation, Cushing allocated a portion of the liabilities assumed for those assets, resulting in a claimed revaluation of $12,105,812. Thus, Cushing claims it incurred a loss of $3,884,742 on the disposition of its assets to Good Samaritan. Prior to the consolidation, the book value of Goddard's total property, play and equipment, net of depreciation was $23,081,891. After the consolidation, Goddard allocated a portion of the liabilities assumed for these assets, resulting in a claimed revaluation of $15,566,664. Thus, Goddard claimed it incurred a loss of $7,515,227 on the disposition of its assets to Good Samaritan.

In filing their fiscal year 1994 cost reports, the Providers requested that they be allowed to recognize as allowable costs the losses they claimed they each incurred on the disposal of their assets to Good Samaritan in connection with the consolidation. Specifically, Goddard claimed a reimbursement of $2,725,225 for

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[1] Provider Exhibit A. As reflected in the consolidation agreement, Goddard Health Planning Corporation and Caritas Christi were the owners of the respective Providers.

[2] The new corporation was originally called Goddard Memorial and Cardinal Cushing Medical Center, Inc.

[3] Intermediary Exhibit 52.

the previously unrecognized depreciation of its assets, and Cushing claimed a reimbursement of $ 880,614 for the previously unrecognized depreciation of its assets. By letter dated April 30, 1996, the Intermediary denied the claims, asserting "the consolidation was between related parties … since the members of the Boards of Directors for both Cushing and Goddard before the consolidation were essentially the same as the members of the Board of Trustees for the Good Samaritan after the consolidation."

The Intermediary issued NPRs to both Cushing's and Goddard's on April 29, 1996. However, neither NPR contained an adjustment with respect to the losses at either facility, since neither facility had claimed a loss on its cost reports.[4]

ISSUE AND BOARD'S DECISION

The issue is whether there was recognizable loss upon the transfer of assets to Good Samaritan Medical Center from Goddard Memorial Hospital and Cardinal Cushing Hospital that occurred in connection with the consolidation of the two hospitals and the resulting creation of Good Samaritan Medical Center.

The Board found that the Providers were unrelated under the Medicare regulation at 42 CFR.413.134(1)(3), and that revaluation of assets and recognition of gain or loss incurred as a result of the consolidation is required. The Board looked to the related party regulation, 42 CFR 413.17, to determine whether the consolidation was between unrelated parties. The Board concluded that based upon the plain language of the consolidation regulation, the related party concept only applies to the entities that are consolidating. Further, the Secretary's intent in drafting the regulation was to only look at the relationship prior to the transaction, and not the relationship after the transaction. The Board, therefore, concluded that the plain language of the regulation

[4] As a preliminary matter, the record shows that the Providers were allowed by the Intermediary to continue to file separate cost reports after the consolidation due to system needs and, thus, did not file terminating costs reports as would be expected following the consolidation. The Providers instead filed a notice with their 1994 cost reports requesting the loss on the disposition of assets. Due to the unique facts of this case, this Administrator does not dispute the timing of the Providers appeal. Moreover, as noted below, the Administrator finds that the terms of Bethesda apply in this case, as the Intermediary did not have the authority to grant the relief requested by the Providers. The Administrator also notes that jurisdiction can always be raised. The Board's letter granting of jurisdiction (of which the Administrator was not formally notified) was interlocutory in nature. The present Board decision disposed of the case in its entirety giving rise to this timely review of jurisdiction.

bars application of the related party principle to the consolidating parties relationship to the new entity.

The Board rejected the Intermediary's argument that the phrase “between related parties” requires that the consolidation transaction be examined for relationships after the transaction as well, and that the relationship between the old and new entities disqualifies the transaction from revaluation of assets. For the same reasons, the Board also found that the Intermediary's arguments that the transaction fails the traditional tests of “bona fide” and “arms length” dealings as applied to Cushing's and Goddard's relationships to Good Samaritan also fails, because Good Samaritan is, by definition, “nothing more than a combination of the old Cushing and Goddard.” Therefore, the Board concluded that this concept bars the type of bargaining between the pre/post transaction entities the Intermediary contends is necessary.

The Board also agreed with the Providers claim that they qualify for Medicare reimbursement of the loss commensurate with the revaluation. The Board looked to the consolidation regulation, 42 CFR 413.134, in the context of the entire regulation on depreciation.

The Board held that evidence of a changing healthcare environment and lack of a market for provider facilities is persuasive that Providers incurred a genuine financial loss. The Board also found that evidence supports the Providers' position that the process of finding a suitable consolidation partner requires arms' length evaluation and bargaining similar to that in traditional sale; although the Board believes it may be more imprecise in producing fair market value. The Board relies on the Medicare Manual to support that view. The Board further determined that the assumption of liabilities through a consolidation transaction is persuasive evidence of acquisition costs. Liabilities assumed in a consolidation also may, but do not necessarily, equate to fair market value.

With regard to the calculation of the loss, the Board concluded that the acquisition cost, that is, the amount of assumed liabilities, should be prorated among all of the Providers' assets. The Board remanded this matter to the Intermediary for consideration of the calculation. The Board determined that the Intermediary's determination to deny the Providers' loss on consolidation was improper.

One member of the Board dissented. The dissent stated that the Board did not have jurisdiction to hear this case, because there was only *some* confusion on the part of the Provider as to whether they were harmed or dissatisfied; there was no claim of loss on the Provider's cost report, thus no adjustment by the Intermediary on final determination; there was no documentation of the required $10,000

threshold, and there was an inability of the Board majority to identify a basis upon which to grant relief. The Dissent relied on Section 1878 of the Act establishing the Provider Reimbursement Review Board, to support this view. The Dissent also stated that the "appeal" was not timely. The Dissent emphasized the fact that there was no loss claimed on any cost report.

Finally the Dissent stated that there has to be evidence of a bona fide sales-characteristic loss-on-consolidation; a claim to Medicare for that loss on a cost report a denial of that claim; and a timely appeal. None of those events appeared in the instant case. The Dissent was also not convinced that the consolidating parties were "unrelated," and agrees with the Intermediary that this was simply a "reorganization under a new name."

SUMMARY OF COMMENTS

The Intermediary commented that the Board's decision on the merits were "seriously flawed" and recommended its reversal. The Intermediary argued that the Board incorrectly assumed jurisdiction and extended its authority to a degree not provided for by statute, regulation or HCFA ruling §405.1875(c)(3). The Intermediary also commented that the Board's holding presents several problems. First, the Providers make no claim for any losses on any cost reports, and the Board's "1994" rule" seems to be formulated solely from the fact that the Providers acknowledge they missed the chance in 1993. The Intermediary argued that the Board erroneously established the "1994 rule." The Intermediary further commented that the Board erred when it assumed jurisdiction over a "claim" addressed in a letter, but not a cost report, and finds that the letter is sufficient evidence that the Providers were dissatisfied with an Intermediary determinations. The Intermediary agreed with the Dissent that a provider's appeal must be made with respect to a cost report, the determination being appealed from must be from a cost report, and the $10,000 in controversy must relate to a determination on the cost report. The Intermediary argued that the Board's determination introduces an element of uncertainty, which the cost reports form and instructions are designed to avoid. The Intermediary also emphasized that no party made any claim on any cost report for any fiscal year for losses on depreciable assets because of the consolidation that established the Good Samaritan Medical Center, and uses *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988), a Supreme Court case to support it's views.

Finally, the Intermediary disagreed with the Board's interpretation that alleged confusion or mistakes in oral or other forms of communication on which a Providers claim to exist and not unexpectedly claims to rely relieved the Providers from the clear dictates of the governing regulations, and program policy and

instructions. The Intermediary comments that the Board erroneously read and construed the factual record.

CMM commented that the case was incorrectly decided and that the Board's decision should be reversed. CMM argued that the Board incorrectly held that the Providers were entitled to claim capital reimbursement as a result of "losses" through "sales" of their facilities upon consolidation. CMM disagreed with the Board's interpretation of 42 CFR §413.134(1)(3), and argued that the better reading that "between two or more corporations that are unrelated" in (1)(3)(i) should include the relationship between the constituent corporations and the consolidated entity. CMM also commented that the Board erred in finding that the Program Memorandum, A-00-76 (Oct. 19, 2000), entitled "Clarification of the application of the Regulations at 42 CFR §413.134(1) to Mergers and Consolidations Involving Non-profit Providers," is not applicable to this case because it was contrary to the plain language of §413.134(1)(3)(i). CMM further argued that even if the Board is correct, the Program Memorandum nevertheless should be given force and effect. CMM commented that the Administrator should find that each Provider has failed to carry its burden that the transaction was not a related party transaction, and each provider's claimed loss should be denied on this basis.

Finally, CMM commented that the Administrator should also reverse the Board's decision that there was a bona fide sale. CMM stated that selling one's assets at fair market value is a necessary component of a bona fide sale. CMM believed the Board also failed to provide any reasoned analysis of how the Providers demonstrated that they obtained fair market value for their assets. Therefore, CMM requested that the Administrator reverse the Board's decision on the basis that the Providers failed to demonstrate that they engaged in bona fide sales of their depreciable assets to the consolidated entity.

The Providers commented requesting that the Administrator affirm the Board's decision. The Providers stated that the review of the jurisdictional decision is not timely, and that this review should be halted on the grounds that it was not begun and completed within the period provided for by law. The Providers further argued that under the governing statute, the Board's decision on its jurisdiction has already become final and binding and is no longer subject to review by the Administrator.

The Providers also stated that the hospital's claims were properly before the Board, and that the Intermediary's argument ignores the special circumstances of this case. The Providers argued that the Intermediary told Goddard and Cushing that because the two campuses of Good Samaritan were using separate provider numbers, they would be required to file separate cost reports for fiscal 1994.

With respect to the argument that there were no claims of loss reported, the Providers argued that the claim of loss was raised in a cover letter rather than in the body of the cost report, and that is not fatal to the hospitals claims. To support its position, the Providers cited to *Com Hosp. Of Roanoke v. Health & Human Serv.*, 707 F.2d 1257, and therefore requested that the Board's decision that it had jurisdiction to hear the Hospitals' appeals be affirmed.

Further, the Providers argue that the Board correctly found that the Providers were unrelated and that recognition of the loss as a result of the consolidation was required under applicable regulations. The Providers argued that they did show that they were not related parties as that term is used in 42 C.F.R. §413.134. The Provider disagreed with CMM's interpretation of 42 C.F.R. §413.134(1)(3)(i).

The Provider also contends that Cushing and Goddard did not need to prove that there was a bona fide "sale." They only needed to demonstrate that there was a bona fide consolidation that was negotiated at arm's length by two corporations that were not related to one another at the time of the transaction. The Providers stated that the consolidation of Cushing and Goddard was an arm's length transaction that resulted in a complete transfer of all of their assets to Good Samaritan for valuable consideration. The Providers used *Black's Law Dictionary* (6\th/ edition), *Ashland Regional Medical Center v. Blue Cross and Blue Shield Assoc.*, and *Lac Qui Parle Hospital of Madison, Inc. v. Blue Cross an Blue Shield Assoc*, to support that the assumption of liabilities is valid consideration for assets purchased and is equivalent to the "purchase price" of the transaction. Further, the Providers used 42 C.F.R. §413.134(b)(2) to support the conclusion that an appraisal is not required to determine fair market value in an arm's length transaction between unrelated parties, and states that the fact that the new entity's Board of trustees was appointed equally by Goddard and Cushing demonstrated that the parties were negotiating at arm's length.

Finally, the Providers further argued that under the applicable regulations, a gain or loss is computed when there is a consolidation between unrelated parties. The Provider contended that, while 42 C.F.R. §413.134(1(3)(i) contains no reference to bona fide sale, it does, however, mandate that revaluation should occur when unrelated parties consolidate. The Provider further stated that a consolidation is not a sale, and disagrees with CMM when it tries "to link and blend the concept" of "sale" with that of "consolidation."

DISCUSSION

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

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

Until 1983, Medicare paid for covered hospital inpatient services on the basis of "reasonable cost." Section 1861(v)(1)(A) of the Act defines "reasonable cost" as "the cost actually incurred," less any costs "unnecessary in the efficient delivery of needed health services." While §1861(v)(1)(A) does not prescribe specific procedures for calculating reasonable costs, it authorizes the Secretary to promulgate regulations setting forth the methods to determine reasonable cost and the items to be included in reimbursable services.

Pursuant to such authority, the Secretary promulgated regulations on capital costs, including depreciation and the gain or loss on the disposal of depreciable assets rendered to patients under the Medicare program. With respect to the determination of reasonable costs, the regulation at 42 C.F.R. §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).

The regulations at 42 C.F.R. §413.134(f) explains the conditions under which depreciable assets may be disposed of in order to be considered reasonable and necessary costs, and thus allowable 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 …

The regulations at 42 C.F.R. §413.134(f)(2) address gain and losses realized from the bona fide sale of depreciable assets and states:

> (2) *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).[5]

With respect to assets sold for lump sum the regulations at 42 C.F.R. §413.134(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….

The regulations at 42 C.F.R. §413.134(f)(4) address gains and losses realized from the exchange, trade-in or donation of depreciable assets and states that: "[g] ains or losses realized from the exchange, trade-in, or donation of depreciable assets are not included in the determination of allowable cost."

Relevant to this case, the regulations at 42 C.F.R §413.134(1)[6] addresses depreciable assets exchanged for capital stock, statutory mergers and consolidation. In addressing the determination of a gain or loss for proprietary corporations that consolidate, the regulation states that:

> (1) *Transactions involving provider's capital stock —*
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> ****
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> (3) *Consolidation.* A consolidation is the combination of two or more corporations resulting in the creation of a new corporate entity.

[5] Section 104.24 of the PRM addresses a bona fide sale and states: "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." Trans. No. 415 (May 2000).

[6] Originally codified at 42 C.F.R. §405.415(1).

> If at least one of the original corporations is a provider, the effect of a consolidation upon Medicare reimbursement for the provider is as follows:
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> (i) *Consolidation between unrelated parties.* If the consolidation is between two or more corporations that are unrelated (as specified in §413.17), the assets of the provider corporation(s) may be revalued in accordance with paragraph (g) of this section.
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> (ii) *Consolidation between related parties.* If the consolidation is between two or more related corporations (*as specified in §413.17*), no revaluation of provider assets is permitted. (Emphasis added.)[7]

With respect to whether parties will be considered related, 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.
>
> (2) *Common ownership.* Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.
>
> (3) *Control.* Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

Consistent with the Act and the regulations, the above principles are set forth in the Provider Reimbursement Manual (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 Section 1004.1 states:

> This rule applies whether the provider organization or supplying organization is a sole proprietorship, partnership, corporation, trust

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

> 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.)[8]

With respect to control, the PRM at Section 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."[9]

To clarify the application of 42 CFR.413.134(1), CMS issued Program Memorandum (PM), A-00-76, dated October 19, 2000, entitled "Clarification of the Application of the Regulations at 42 CFR 413.134(1) to Mergers and Consolidations Involving Non-profit Providers. Program Memorandum, A-00-76-2000. This PM recognized that, inter alia, certain relationships formed as a result of the consolidation of two entities constituted a related party transaction for which a loss on the disposal of assets could not be recognized.

The Intermediary Manual, Chapter 4000, et seq., addresses changes of ownership (CHOW) for purposes of Medicare certification and reimbursement. These sections provide guidelines based on Medicare law, regulations and implementing instructions for use by the Medicare intermediaries and providers on the reimbursement implications of various types of changes of provider organizations transactions or CHOWs. Section 4502 explains that the first review of a CHOW transaction is to determine the type of transaction which occurred as the Medicare program has developed specific policies on the reimbursement effect of various types of CHOW transactions which may be different from treatment under generally accepted accounting principles.

Corporations are included as one of the possible types of provider organizations. Section 4502.1 explains that a corporation is a legal entity which enjoys the rights,

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

[9] The concept of "continuity of control" is illustrated at Section 1011.4 of the PRM, in Example 2. Example 2 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."

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 nonstick entities (members).

Among the various types of provider structures and transactions recognized by Medicare are mergers, consolidations, and corporate reorganizations at section 4502. Section 4502. 7 describes a consolidation as similar to a statutory merger, except that a new corporation is created. Medicare program policy permits a revaluation of assets affected by a corporate consolidation between unrelated parties. Notably, Medicare policy at section 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.

This policy of not recognizing a gain or loss when the transaction consitutes a reorganization 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.[10]

Under IRS rules, some consolidations are considered statutory reorganizations and subject to the non-recognition of a gain or loss. The terms reorganization and consolidation are not mutually exclusive terms under IRS rules. Medicare policy similarly indicates that they are not mutually exclusive terms under Medicare rules. That is, consolidations may in fact constitute reorganizations.[11]

Similar to Medicare rules, the IRS does not allow the recognition of the gain or loss when there is a reorganization, inter alia, because no gain or loss has in fact

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[10] 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), for support that GAAP cannot dictate the Secretary's Medicare policy.

[11] The Administrator also notes that the Providers' certificate of filing refers to this transaction as a consolidation. Intermediary Exhibit 52. However, mergers and consolidations appear to also be referred to as "reorganizations" under Massachusetts law. See, e.g., Emhart Corporation v. State Tax Commission, 363 Mass.429 (1973)(referring to corporations that participate in merger, consolidation or "other reorganizations"). See also Black Law Dictionary definition of a reorganization used interchangeably with merger and consolidation ("A reorganization that involves a merger or consolidation under a specific State statute.")

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 by an exchange of stock for stock."[12] (Emphasis added.)

Similarly, the courts have stated that the underlying purpose of the 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."[13] 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." 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 is to avoid the payment of costs not actually incurred by the parties.

In this particular case, the record shows that the assets of old corporations, Cushing and Goddard, were transferred to a newly created corporation for the value of their liabilities. As the corporations were nonstock issuing, there was no transfer of stock, rather members of certificate were issued. The new members of the newly created corporation were the owners of the former two constituent corporations, Caritas Christi and Goddard Health Planning Corporation. The Board of Trustees for the new corporation was appointed by the constituent corporations and comprised 87.5 percent of the new Board of Trustees. Of the 24 members of the Board of Trustees newly established corporation, 12 were appointed by Cushing and 12 by Goddard.[14] The high level officers of the new

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[12] Commissioners of IRS v. Webster Estates, 131 F. 2d 426, 429 (2nd Cir.1942) citing Helvering v. Schoellkopf, 100 F. 2d 415 (2d Cir).

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

[14] Of those 24 chosen for the new board, only three were not current members of the Board of either Cushing or Goddard.

corporation (Chairman and Vice Chairman) were appointed by the constituent corporations, while the President and Vice President were in turn appointed by the Board of Trustees. The new Board of Trustees authority was subject to the power and reserved power of the new "members." In total, the composition of the old corporations and new corporation members, Board of Trustees and Officials show a continuity of control between the old corporations and the new corporation. Finally, the new corporation, similar to old corporations, was formed to continue the business of providing health care .to the community. Thus, after a review of the record, the Administrator finds that the consolidation constituted a reorganization of the Providers and, thus, as the parties were related, no loss on sale may be recognized by the Medicare program.

The Administrator finds that the rationale for finding that this transaction constitutes a related party transaction under Medicare policy is compelling. An overarching principle of Medicare reimbursement, which serves as the basis for the prophylactic related party rule, is that only costs actually incurred are reimbursable under Medicare. In this case, inter alia, the constituent corporations' owners were the sole two members of the newly formed corporation and had continuity of control through the members, the Board of Trustees and the officials of the newly formed corporation, along with a transfer of all the assets of the old corporation to the new corporation. Thus, it is reasonable to find that the old corporations same interests have been but recast in a different form only and, thus, a loss has not actually been incurred by the old corporations that can be recognized by Medicare.[15]

Moreover, the Administrator finds that it is a permissible and rational reading of 42 CFR 413.134(1)(3)(i) that "between two or more corporations that are unrelated" should include the relationship between the constituent hospitals and the consolidating entity. The Administrator disagrees with the Board's interpretation that the related party concept only applies to relationships prior to the transaction, and not to the relationships after the transaction. Such a policy suggested by the Board, forbidding the examination of relationships after the transaction, would, inter alia, preclude the agency from determining when a transaction constituted a reorganization.

As Program Memorandum, A-00-76 states: "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

[15] Therefore, regardless of whether this transaction qualifies as a reorganization under present Federal or State tax rules and is treated as a non recognizable loss, it cannot be allowed under Medicare rules as a loss on the disposition of assets.

corporation that transfers assets and the corporation that receives them." Furthermore, HCFA Ruling 80-4 (HCFAR 80-4) holds that, "applicability of the related organization rule which limits costs of a provider to those of its supplier is not necessarily determined by the absence of a relationship between the parties prior to their initial contracting, although this fact is 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…. (Emphasis added.) Similarly, the consolidation agreement in this case established a relationship between the Providers and the new corporation reflected by a continuity of control.

Accordingly, the Administrator finds that the record contains compelling evidence on the relatedness of the consolidating corporations and the newly established corporation. The Administrator finds that, consistent with a finding that this consolidation represents a reorganization, these facts represents "significant" ownership and control. Thus, based on the facts of this case, the Administrator finds that the parties were related according to 42 C.F.R §413.17 and a loss on the disposal of assets cannot be recognized under Medicare.

In sum, the Administrator finds that the transaction at issue in this case involved related parties and, thus, Medicare cannot recognize a loss on the transfer of the assets.[16]

[16] After a review of the facts, the Administrator finds that the transaction was not a bona fide sale as the transaction did not involve arms' length transaction as it involved related organization, with no evidence that appraisals of the fair market value of the assets had been sought or conducted, nor a determination of whether fair consideration was given for the assets, all indicative of a non bona fide transfer of the Providers' assets. Finally, because the parties are not related and not allowable, no intermediary determination has been made as to the amount of Medicare's share in any proposed loss.

DECISION

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

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

Date: 1/29/03 /s/

Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services