# CENTERS FOR MEDICARE AND MEDICAID SERVICES

## *Decision of the Administrator*

| **In the case of:** | **Claim for:** |
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| **St. Francis Regional Medical Center** | **Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 09/30/96** |
| **Provider** | |
| **vs.** | |
| **Blue Cross Blue Shield Association/ Blue Cross Blue Shield of Kansas** | **Review of: PRRB Dec. No. 2009-D29 Dated: July 8, 2009** |
| **Intermediary** | |

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

## ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's adjustments disallowing a loss claimed by St. Francis Regional Medical Center upon its consolidation with St. Joseph Medical Center to form Via Christi Regional Medical Center was proper.

The Board held that the Intermediary's adjustment disallowing the Provider's claimed loss on disposition of assets due to a change of ownership resulting from a consolidation was contrary to the regulatory requirements of 42 CFR

§413.134(1)(3)(i) and reversed the Intermediary's decision. The Board also remanded the matter back to the Intermediary for proper calculation of the loss pursuant to the governing regulatory and manual provisions.

The Board found that the Provider and St. Joseph were unrelated parties as that term is defined under the regulatory provisions of 42 C.F.R. §413.7 and 42 CFR §413.134. Accordingly, a revaluation of the assets and a recognition of the loss incurred as a result of the consolidation is required under the plain meaning of 42 CFR §413.134(1)(3)(i).

The Board rejected the Intermediary's assertion that an examination of the relationship of both the parties prior to and after the consolidation is appropriate. The Board concluded that the plain language of the regulation barred application of the related party principle to post-consolidation relationships. The Board concluded that the regulation only required that the parties prior to the consolidation not be related.

The Board found that the transaction that resulted in the formation of Via Christi was a *bona fide* transaction under Kansas corporation law. The board stated that the completed transaction consolidated two hospital corporations into one new entity, with the preexisting entities ceasing to exist. Contrary to the "continuity of control" doctrine embodied in PM A-00-76, the Board found that such an interpretation of the related party regulation is not only inconsistent with the regulation governing consolidations, but it also ignores the very nature of a consolidation.

The Board acknowledged that the Administrator reversed a series of cases that were virtually identical to the case at bar based upon HCFA Ruling 80-4 and the regulations at CFR §413.17. The Board, however, stated that since the issue under appeal concerns the recognition of losses on the transfer of assets resulting from a consolidation, the Board cannot limit its review only to the related party rules, but it must also view the transaction in light of the specific consolidation regulations at 42 CFR §413.134(1)(3).

Finally the Board found that the transaction was not required to meet the criteria of a *bona fide* sale, only a *bona fide* transaction. The Board stated that it has consistently rejected the position that requires the transaction to be a "bona fide sale," finding instead that when the regulation was amended to add 42 CFR §413.134(1), it expanded the disposition methods listed in section (f) to include consolidations and mergers; it did not require fitting consolidations and mergers into one of the disposition methods already listed.

Furthermore, despite the lack of nexus between liabilities assumed and fair market value using liabilities assumed as the acquisition cost is supportable. 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.

## SUMMARY OF COMMENTS

### Intermediary Comments

The Intermediary pointed out that the Provider in this case was the other merger participant in *St. Joseph's Medical Center*, PRRB Decision No. 2003-D64. After the Boards' decision in support of St. Joseph's similar postured loss claim was reversed by the Administrator, the controversy was reviewed by both the St. Francis's home Federal District Court (U.S. District Court of Kansas) and the 10th Circuit Court of Appeals. The Board's decision in the case at bar noted that the Administrator's decision was affirmed at the District Court and affirmed in part and reversed in part in *Via Christi Regional Medical Center, Inc., v. Leavitt,* 509 F.3d 1259 (10th Cir. Dec. 7, 2007).

The Intermediary emphasized that the Board side stepped the 10th Circuit decision rather than acknowledging and confronting the Court's rejection of the loss claim for the other participant in this consolidation based on the "bona fide" sale test. The Tenth Circuit decision made it clear that the bona fide sale standard applied and that the consolidation was not a bona fide sale. Hence, the Provider in the case at bar, is in no better position than St. Joseph was in the previous case.

### CMM Comments

CMM commented requesting that the Administrator reverse the Board's decision. CMM stated that the precedents established in St. Joseph Medical Center and in *Via Christi Regional Medical Center, Inc.*, by the District Court of Kansas and the Tenth Circuit for the bona fide sale argument control the outcome of this case.

A consolidating provider must comply with the requirements of 42 C.F.R. §413.134(f). In St. Francis, the transfer of assets did not constitute a bona fide sale. There was no evidence of arm's length bargaining, or an effort to maximize the sale price. The circumstances in this case are similar to St. Joseph; therefore the Board cannot ignore the ruling by the 10th Circuit Court.

The principals of St. Joseph did not approach any other entity about a consolidation and were not attempting to get the full value for its assets. They did not put St. Joseph up for sale because they felt it would not have fulfilled their desire to perpetuate the Catholic health care ministry in the community. The facts are similar

in St. Francis. The principals were not interested in selling the assets and their primary focus was consolidating to form an entity that would advance their ministry. Therefore, there was no bona fide sale.

**Provider's Comments**

The Provider commented requesting that the Administrator affirm the Board's decision. The Provider stated that for reasons previously set forth in its Post-Hearing Brief for St. Francis Regional Medical Center and its letters to the Board, dated December 11, 2007 and January 25, 2008, that the Board's decision was consistent with the pertinent laws, regulations and policies that require recognition of a loss from consolidation between unrelated parties.[1]

In the Provider's December 11, 2007 letter, the Provider noted that *Via Christi Regional Medical Center v. Leavitt,* 509 F.3d 1259 (10 Cir. 2007) did not require disallowance of St. Francis Regional Medical Center's loss on claim. Additionally, in the Provider's letter dated January 25, 2008, the Provider addressed the agency's failure to list the 2000 Program Memorandum in the Federal Register as required by 42 U.S.C. §1395hh(c)(1).

The Provider also responded to the assertions made by the Intermediary's comments and CMM's Memo by stating that the Deputy Administrator in *Mercy Community Hospital,* PRRB Dec. No. 82-D133 has said "Under the [recapture] regulation, the assets should be appraised after the sale for purposes of allocation." The Provider further noted that the Administrator's decision was upheld by the United States District Court for the Middle District of Florida in *Mercy Community v. Heckler,* 781 F.2d 1552 (11th Cir. 1986).

## 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.

[1] The Provider also questioned the timeliness of CMM comments. However, under the revised version of definitions under 42 CFR 405.1801 "receipt" is presumed as at least 5 days.

## I. Medicare Law and Policy -- Reasonable Costs.

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

### A. Capital Related Costs.

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

Title VI of the Social Security Amendments of 1983[2] added §1886(d) to the Act and established the prospective payment system (PPS) for reimbursement of inpatient hospital services provided to Medicare beneficiaries. Under this system, hospitals are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge according to a list of diagnosis-related groups. Reimbursement under the prospective payment rate is limited to inpatient operating costs. The Social Security Amendments of 1983[3] amended subsection (a) (4) of §1886 of the Act to add a last sentence, which specifies that the term “operating costs of inpatient hospital services”, does not include "capital-related costs (as defined by the Secretary for periods before October 1, 1986)....” That provision was subsequently amended until finally, §4006(b) of OBRA 1987 revised §1886(g)(1) of the Act to require the Secretary to establish a prospective payment system for the capital-related costs of PPS hospitals for cost reporting periods beginning in fiscal year (FY) 1992.

#### 1. Depreciation.

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[2] Pub. Law 98-21.

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

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

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

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

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

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

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

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

> (1) Net depreciation expense as determined under §§ 413.134, 413.144, and 413.149, adjusted by gains and losses realized from the disposal of depreciable assets under 413.134(f). (Emphasis added.)

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

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

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

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

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

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

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

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

> amount of depreciation previously included in Medicare allowable costs. The amount of a loss to be included is limited to the un-depreciated basis of the asset permitted under the program. The treatment of the gain or loss depends upon the manner of disposition of the asset, as specified in paragraphs (f)(2) through (6) of this section ….(Emphasis added.)

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

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

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

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

Paragraph (f)(3) addresses gains or losses realized from sales within 1 year after the provider terminates from the program, while §413.134(f)(4) addresses exchange trade-in or donation[8] of the asset stating that: "[g]ains or losses realized from the exchange, trade-in, or donation of depreciable assets are not included in the determination of allowable cost." Finally, paragraph (f) (5) explains that the treatment of gains and losses when there has been an abandonment (permanent retirement) of the asset, and paragraph (f)(6) explains the treatment when there has been an involuntary conversion, such as condemnation, fire, theft or other casualty.

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

[8] A donation is defined in §413.134((b)(8). An asset is considered donated when the provider acquires the assets without making payment in the form of cash, new debt, assumed debt, property or services. Section 4502.12 of the Intermediary Manual states that when a provider is donated as an ongoing facility to an unrelated party, there is no gain/loss allowed to the donor. The valuation of the assets to the donor depends upon use of the assets prior to the donation.

**2. Revaluation of Assets.**

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

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

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

[10] (2002) Redesignated from paragraph (l). Originally codified at 42 CFR §405.415(l).

> *(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).[11]

However, paragraph (k) is silent with respect to the determination of a gain or loss for corporations that consolidate.

**B. Related Organizations**

Finally, 42 CFR § 413.134 references the related organization rules at 42 CFR §413.17. The regulations at 42 CFR § 413.17, states, in pertinent part:

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

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

> assets of the organization (e.g., a reversionary interest provided for in the articles of incorporation of a nonprofit corporation).[12]

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

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

The related party organization was further explained in HCFA Ruling 80-4, which adopted the Eighth Circuit Court of Appeals' decision in Medical Center of Independence v. Harris, (CCH) Para. 30,656 (8th Cir. 1980). The Ruling pointed out that the applicability of the related organization rule is not necessarily determined by the absence of a relationship between the parties prior to their initial contracting, although those factors are to be considered. The applicability of the rule is determined by also considering the relationship between the parties according to the rights created by their contract. The terms of the contracts and events, which occurred subsequent to the execution of the contract, in that case had the effect of placing the provider under the control of the supplier.

### C. Non-Profit Corporations and the Related Parties and Disposal of Depreciable Asset Regulations.

#### 1. Program Memorandum A-00-76.

To clarify the application of 42 CFR § 413.134(k) 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.[13] This PM applies the foregoing regulations to the situation of non-profit corporations. In particular, this PM noted that non-profits differ in significant

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

[13] PM A-01-96 (Aug. 7, 2001) replaced A-00-76. The only change was a new discard date.

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 CFR § 413.134(k) 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 CFR § 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 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 CFR § 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 413.134(k) and as defined in the PRM at section 104.24. The PM stated that the regulation at 42 C.F.R. § 413.134(k) 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.

The PM policy of examining the relationship between the corporation that transfers the assets and the corporation that receives the assets, does not obviate the application of the gain and loss provisions in all transactions involving a consolidation. For example the PM illustrates circumstance when there isa consolidation that results in the calculation of a gain or loss. The PM Example 2 explains that:

> Corporation A and B consolidate to form Corporation C. Corporation A and B were unrelated prior to the transaction, each being controlled by its respective Board of Directors of eight members each. After the consolidation, Corporation C's Board of Directors consists of seven individuals, all of whom were members of Corporation A's board. Because no significant change of control of assets of corporation A occurred, the transaction as between A and C is deemed to be one of related parties and no gain and loss on it will be recognized as a result of the transaction. However, because there has been a significant change of control of the assets of Corporation B, the transaction as between B and C is not one of the related parties. Therefore, with respect to the assets transferred from B to C, a gain or loss may be recognized (if the other criteria for recognizing a gain or loss, including the requirement of a bona fide sale are met.)

As set forth in the foregoing example, a rule that looks at the parties before and after the transaction does not make superfluous the gain or loss provisions whenever there is a consolidation or merger. For example, only in circumstances where there is a continuity of control between the former owner of the assets and the new owner of the assets is the transfer recognized as between related parties and no gain or loss allowed.

Notably, the Administrator finds that requirement that the term "between related organizations" includes an examination of the relationship before and after a transfer of assets under 42 CFR § 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.[14] The agency looked specifically at whether, in a related party transaction, the control and extent of the financial interest remained the same for the owners of the provider before and after the termination.[15] 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 consolidation of entities: the deal is initially between the consolidating entities, but, as part of the consolidation, they will cease to exist effective with the consolidation. In contrast, the transfer of the assets is between the consolidating entities and the newly created corporation. Thus, the parties to the transaction involve the consolidation corporations and the newly created corporation. Hence, Medicare reasonably examines the relationship between the consolidating corporations (transferor) and the newly created corporation and recipient of the Medicare depreciable assets (transferee) to determine whether the transfer involved a related party transaction.

Finally, this interpretation set forth in the PM is also consistent with the language of 42 CFR 413.134(k) that refers to "between two or more corporations that are related" with respect to proprietary corporations. CMS has always recognized a

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[14] 42 Fed. Reg. 45897 (1977).

[15] 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.)

consolidation as a transaction wherein two or more corporations combine to create a new corporation. That is, CMS has always recognized that the parties to a consolidation are the consolidating corporations *and* the newly created corporation. Therefore, CMS has reasonably applied the related parties rules in requiring an examination of the relationships of the parties to the consolidation: the consolidating corporations and the newly created corporation.

**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 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 or GAAP.

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, privileges and responsibilities of an individual under the law. The 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 of the Manual. 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 § 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 reorganization, CMS examines, inter alia, the parties before and after the transaction in determining that the transfer of assets involved a related party transaction.

Section 4508.11 of the Intermediary Manual,[16] in addressing stock corporations states that the Medicare program policy places reliance on the generally accepted accounting principles or GAAP, as expressed in Accounting Principles Bulletin (APB) No. 16, in the reevaluation of assets and gain/loss computation processes for Medicare reimbursement purposes. While in certain areas, Medicare program policy deviates from that set forth in GAAP,[17] Intermediaries are instructed to refer to the principles outlined in the CHOW manual which specify when reference to APB No. 16 is in accordance with the current Medicare policy.[18]

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

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[16] Section 4504.1 states that: "where Medicare instructions are silent as to the valuation of consideration given in an acquisition, rely upon generally accepted accounting principles. APB No. 16 discusses valuation methods of consideration given for assets acquired in business combinations."

[17] For example, Medicare will not recognize a revaluation/gain or loss due to a transfer of stock or in the case of a "two-step" transaction (i.e., the transfer of stock, than the transfer of the depreciable assets).

[18] Effective June 2001, APB No. 16 and the pooling of interest provision were rescinded, leaving only the "purchase" method of accounting for business combinations. The CHOW does not reflect or adopt this change. Moreover, while FASB No. 141 did replace APB No. 16 effective June 2001, at the present, not-for-profit (NFP) organizations are excluded from the scope of FASB No. 141.

both recognize and treat the pooling of interests in a business combination as an event resulting in no gain or loss, while recognizing and treating a bona fide purchase or sale in a business combination as an event resulting in a gain or loss.

### D. Similarities of Internal Revenue Service Principles and Medicare Reimbursement Principles When Entities Consolidate.

This policy of not recognizing a gain or loss when the transaction is between related parties, whether it constitutes a reorganization or consolidation, 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.[19] In fact, in setting forth principles applicable to the recognition of the gain or a loss, CMS has in the past recognized the similarity of the Medicare principles and the IRS principles and has often explicitly stated when such Medicare policy agrees or diverges from IRS treatment.[20]

Under IRS rules, some mergers 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 and mergers may in fact constitute in essence, reorganizations and reorganizations may involve more than one corporation.[21] For example, a consolidation, where the predecessor corporation board continues to

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[19] 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).

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

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

control in the new corporation board, is treated the same as a reorganization for Medicare reimbursement purposes and no gain or loss is recognized. However, for example, where the predecessor corporation board does not continue 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.[22] (Emphasis added.)

Similarly, the courts have stated that the underlying purpose of the IRS provisions that find no gain or loss when there is a reorganization was twofold: "1) to relieve certain types of corporate reorganizations from taxation which seemed oppressively premature and 2) to prevent taxpayer's from taking losses on account of wash sales and other fictitious exchanges."[23] 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

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[22] 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 case illustrates the continuity of interest concept, the Administrator notes that the Medicare program does not recognize a loss on sale as a result of the transfer of stock regardless of the relationship of the parties.) Case law also shows that term "continuity of interest" as provided in the IRS regulation is at times used interchangeably with the term "continuity of control." See e.g. New Jersey Mortgage and Title Co. v. Commissioner of the IRS, 3 T. C. 1277 (1944); Detroit–Michigan Stove Company v. U.S., 128 Ct. Cl. 585 (1954).

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

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."[24]

The IRS rules also deny gains or losses from the sale or exchange of property between related parties. In explaining the rationale for this tax law provision, the court in Unionbancal Corporation v. Commissioner, 305 F. 2d 976 (2001), explained that:

> This limitation on deductions for transfers between related parties, protects the fisc against sham transactions and manipulations without economic substance. Not infrequently though, there are honest and important non-tax reasons for sales between related parties, so it's important to fairness to preserve the pre-sale basis where loss on the sale itself isn't recognized for tax purposes. Otherwise the statute would be a heads-I-win, tails-you-lose provision for the IRS: the seller can't take the loss, but the IRS calculates the buyer's gain on resale using the lower basis.

Consequently, one purpose of the IRS policy on reorganization or consolidations between related parties 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, or consolidation 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 as a result of a consolidation. The Transaction was first examined in St Joseph Medical Center, PRRB Dec. No. 2003-D64 and litigated in the Via Christi Regional Medical

[24] 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)).

Center, Inc., v. Leavitt, 509F.3d 1259 (10th Cir. Dec., 7, 2007).[25] This case involves the other provider, St. Francis, which was involved in the consolidation. The transaction involved the St. Joseph Medical Center and the Provider, St. Francis Regional Medical Center. The Master Plan of Consolidation showed that CSJ Health System of Wichita was the parent corporation and sole member (i.e., nonprofit equivalent of stockholder) of St. Joseph Medical Center.[26] Both CSJ Health System and the St Joseph operated under the "sponsorship" of the Sisters of St. Joseph of Wichita Kansas. The Plan also showed that St. Francis Ministry Corporation was the parent corporation and sole corporate member of St. Francis Regional Medical Center (the Provider). The St. Francis Ministry Corporation, the parent company of St. Francis Regional Medical Center was operated under the "sponsorship" of the Sisters of the Sorrowful Mother.

The Plan provided for the consolidation of the constituent parent corporations to create a new parent corporation, Via Christi Health, and the constituent hospitals to consolidation to form a new hospital corporation, Via Christi Regional Medical Center. The voting members of the new parent corporation, Via Christi Health, were the Sisters of St. Joseph of Wichita Kansas and the Sisters of Sorrowful Mother, the Provider's corporate parent's sole sponsor and member. The Plan provided for the consolidation to be effective October 1, 1995.

The Plan also provided, under Article 2.3, that the board of directors of the new hospital, Via Christi Regional Medical Center, would include representatives of the constituent hospitals, St. Joseph and St. Francis, to insure the continuation of the existing commonality of interest. In addition, Article 8 stated that the president of the new consolidated hospital would be appointed by the corporate member of the new hospital (who in turn was comprised of the two members, the Sisters of St. Joseph and the Sisters of Sorrowful Mother.) The board of directors of the consolidated hospital was to approve the senior management of the new hospital as selected by the president.[27]

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[25] The Board and the Administrator has previously considered the loss on consolidation claim of St. Joseph Medical Center in *St. Joseph Medical Center*, PRRB Dec. No. 2003-D64, September 29, 2003, Medicare & Medicaid Guide, rev'd, CMS Administrator, November 25, 2003, aff'd, *Via Christi Regional Medical Center, Inc. v. Leavitt*, No. 04-1026-WEB (D. Kansas Sept, 25, 2006), aff'd, *Via Christi Regional Medical Center, Inc. v. Leavitt*, 509 F.3d 1259 (10th Cir. Dec. 7, 2007). The Administrator herein takes notice and incorporates by reference the Administrator decision in St Joseph Medical Center, PRRB Dec. No. 2003-D64 and the administrative record and factual findings cited therein.

[26] See Master Plan of Consolidation, Provider Exhibit P- 1.

[27] Exhibit P-1.

The Certificate of Consolidation of the constituent hospitals, dated September 29, 1995, was adopted by the Provider after duly held meetings of the board of directors of St Joseph Medical Center, CSJ Health System and the Sisters of St. Joseph of Wichita Kansas and the St. Francis Hospital.[28]

The Corporation Bylaws of the consolidated hospital, Via Christi Regional Medical Center, stated that the consolidated hospital was sponsored by and was an incorporated ministry of the Sisters of Sorrowful Mother and the Sisters of St Joseph of Wichita Kansas.[29] The sponsors established Via Christi Health System to develop, focus and coordinate and extend their resources in accordance with their health mission. The new consolidated hospital was part of the Via Christi Health System, which was formed to assist the sponsors achieve their ministry in healthcare. The Corporation Bylaws at Section 2.2 show that the sole voting member, Via Christi Health, had the power, inter alia, to appoint all directors of the new consolidated medical center, appoint the president of the medical center and retained the right to remove all directors of the medical center.

The Provider filed a terminating Medicare cost report for the fiscal year ending (FYE September 30, 1995) which included a depreciation adjustment that recognized a loss on disposal of assets resulting from the consolidation. Upon audit of the cost report and the loss calculations of the Provider, the Intermediary issued a Notice of Program Reimbursement (NPR) denying the claimed loss.

## A. Related Party, Continuity & Control

As an initial matter, the Administrator notes the interaction of the various regulations on 42 CFR §413.134(k)[30] and finds that, as the issue under appeal

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[28] *See St. Joseph Medical Center*, PRRB Dec. No. 2003-D64, n. 32 Exhibit 1. Certificate of Consolidation.

[29] Exhibit P-40, Corporate By Laws of Via Christi.

[30] The CMS policy on consolidation revaluations in the final rule published Feb 5, 1979 was not a change from the proposed rule published in April 1, 1977. 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

involves the recognition of depreciation losses on the transfers of assets from a consolidation between non-profit entities, one cannot limit the review to 42 CFR §412.134(k). Paragraph (k) was drafted specifically to address the revaluation of assets for proprietary corporations that consolidate, 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 recognition of gains or losses at paragraph §413.134(f). Instead, the Secretary explicitly stated that this provision was promulgated consistent with both the related party rules and the disposal of depreciable asset rules set forth at paragraph (f) and thus must be interpreted consistent with those provisions.[31] Thus, the Administrator finds that the transaction is properly evaluated under both the related party rules and the rules controlling when a gain or loss will be recognized under the Medicare program.[32]

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rule is that the final rule dedicates separate paragraphs to related and unrelated transactions involving consolidations, similar to that provided 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.

[31] *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.")

[32] The Administrator finds that the Board's suggestion that the consolidation need only be evaluated as to whether it was a bona fide (e.g. honest in good faith, etc.) rather than a bona fide sale is erroneous. Not only is such a proposed standard not consistent with the plain language of the controlling regulations and Medicare policy, but such a standard does not ensure that the Medicare program is paying

The Administrator finds applying the foregoing provisions to the facts of this case, that the Provider is not entitled to a loss on sale. The Administrator finds that the transaction involved a related party transaction because of the relationship between the Provider and the consolidated hospital. The record demonstrates that the Sisters of Sorrowful Mother, the sponsoring corporation of the Provider, was a related party and was one of two voting members of the new parent corporation of the post-consolidation hospital. While the related party sponsoring corporation had diluted voting powers by 50 percent after the consolidation, it had 50 percent voting powers of the combined assets of two hospitals, which the Administrator finds comparable to its pre-consolidation powers.[33] While involving two parties, in light of the sponsors continued presence as the sponsors of a new entity having the same mission, function and assets as the pre-consolidation entities, this situation is similar to the related party transaction that occurs during a "reorganization", as exemplified at section 4502.10 of the CHOW Manual, where no loss is allowed.

The record also shows that the post-consolidation hospital governing board included at least seven members appointed from the St. Joseph pre-consolidation board, at least six members appointed from the Provider's pre-consolidated (St. Francis) board, and approximately 10 new members for a total of 23 post-

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"reasonable cost,", which can only be ensure if the consolidation involved an arm's length bona fide sale.

[33] *See also* Transcript of Oral Hearing, (Tr.) at 190 ( "A … In a not-for-profit entity, it has no shareholders, but it has members. So members equate to shareholders and shareholders are the people who are the owners, if you will of the organization…".) ("Q. [H]ow was it that the [members], how were they able as two sponsors…. with similar missions but not necessarily the same mission, how were they able to come together and work as a cohesive unit……. A They have their, I guess, distinct "careism', as they call it, their goals to achieve.. But they are very similar when it gets down to it,….. A. And they, as sponsors have, I think recognize that even though they don't like to speak in these terms, healthcare has become very complicated. And so they have created the organizations, and they look to lay people who are not professed religious, … to assist them in carrying out their mission of service. And they do that through these reserve powers from their organization down to the parent and the parent in turn operates these operating entities that are hospitals….. down on the ground working with the people."

consolidating governing board.[34] The Administrator concludes that a significant number of the members of the Provider's governing board were appointed to the new governing board. The Provider and its related party sponsoring corporation retained and continued to have a significant control of its asset. Post-consolidation, the former board members of the hospital had approximately a 1/3 to ¼ control over the combined assets of the two hospitals. The Administrator finds that, for the Provider, the post-consolidation 1/3 to ¼ control, was comparable to the pre-consolidation control. This interest represented a continuing significant interest when measured in proportion to the combined assets of the hospitals.[35] More importantly, regardless of the number of board members, the record shows that the pre-consolidation "sponsor" of the Provider was one of the only two members of the post-consolidation parent Via Christi. Under the Via Christi Regional Medical

[34] Intermediary Exhibit I-6 listing directors and showing six of the same board members. *But see* Tr. at 164 (Witness testimony that there were eight «St». Francis board members that transferred to the consolidated entity.)

[35] *See also* Exhibit P-34. Prior to the consolidation effective date, the merger team sought opinions on the impact the transaction structure would have on Medicare reimbursement. A consultant letter, dated January 3, 1995, stated that as Medicare would most likely look at the pre/post relationship of the consolidated entities, approximately one third of the members of the new boards of directors for the new parent and the new provider should not be current board members of the consolidated organizations. The letter also outlined the reimbursement effect for the loss on sale for both hospital estimated at between $22,400,000-30,000,000. An April 25, 1995 consultant letter further indicates in detail certain CMS staff's concerns regarding non-for-profit consolidations and the Medicare requirement that the relationship of the pre/post consolidated boards be examined. The letter also noted that the CMS staff felt that a post-consolidated board comprised of $^{1}/_{3}$ pre-consolidation board members may constitute significant control or influence and, consequently, be considered related organization. A consultant letter dated January 23, 1995, addressed the timing of the receipt any reimbursement from the loss on sale including the possible need for court action and again stressing the suggested new board composition of $^{1}/_{3}$ new board members. *See also* April 28, 1995 letter. A consultant letter dated June 23, 1995, again stated that Medicare would most likely look at the relationship between the Provider's pre/post-consolidation board and, therefore, encouraged that the consolidation be structured in such a manner which minimized the relationship between the consolidating organization, the parents and the new provider.

Center Corporation Bylaws, the sponsors through the parent Via Christi had control over, *inter alia* , the appointment and removal of Board members.[36]

The Administrator finds that the rationale for finding that this entire 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. Thus, it is reasonable to find in this case the constituent corporations' same 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.[37]

The Administrator finds that the common criteria between IRS rules and Medicare rules is that a transaction is treated similar to, or as, a reorganization (in that no gain or loss is recognized), regardless of the transaction title, when there is a continuity of interest or control between the constituent corporations and the new corporation. That is, evidence of a continuity of interest or control, is evidence that the entities have but recast their interests in another form, as in a reorganization, and no actual loss has been incurred. The reasonable cost rules must be interpreted consistent with this economic reality.

These facts evidence a continuity of control between the Provider hospital, the related party parent and sponsoring corporation and the post-consolidation hospital, related party parent and sponsoring corporation.[38] There was also a

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[36] In addition, a significant number of officials from St. Francis continued in the new organization at the consolidated entity level including Linda Francisco, Mike Wescott, Keith Lindquist and Bill Vanaski.

[37] 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.

[38] While the Provider argues that the sponsoring organizations did not control the hospital, the testimony and corporate structure shows that it was the sponsors that ultimately made the most significant decision- to consolidate- and also continued to exist in their same roles as the sole members of the consolidated entity's parent after the transaction. *See* Tr. at 64 ("Q. Who made the decision for St. Joseph and St. Francis to consolidate? A. The religious organizations of the hospitals made that decision. Q. And do you know the basis for that decision. A. There was concern, of course with the competitive situation, the need to work together with the consolidation they could strategically plan together, which they could not without consolidation. There was expectation of the economies of scale that would result from the consolidation.")

continuity of business enterprise and purpose between the Provider, its related party parent and sponsoring corporation and these post-consolidation entities.[39] Accordingly, the Administrator finds that the record contains compelling evidence on the relatedness of the Provider and the consolidated hospital. The "transferor" or owner, in a practical sense, of the depreciable assets was, in essence, also the "transferee" of the depreciable assets. The Administrator finds that these facts represent "significant" control. Based on the facts of this case, the Administrator finds that the parties were related according to 42 CFR §413.17 and a loss on the disposal of assets cannot be recognized under Medicare.

**B. Bona Fide Sale & Reasonable Consideration**

In addition, the Administrator finds that the disposal of asset rules of paragraph (f) are properly applied in the event of a consolidation. This means that in order for a loss to be recognized, a transaction resulting in the transfer of depreciable assets must meet one of the applicable criteria of paragraph (f).

Applying the rules to the facts of this case, the Administrator finds that the transfer of the assets did not constitute a bona fide sale and the Provider failed to meet any other criteria under which a loss on the disposal of assets will be recognized at §413.134(f).[40] In this case, there is no evidence in the record of arm's length

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[39] *See* e.g. Provider Exhibit P-33 "1996 Strategic Plan" stating mission of new consolidated entity "to further the healthcare ministry of its sponsoring congregations, the Sister of the Sorrowful Mother and Sisters of St Joseph." *See*, e.g . Transcript of Oral Hearing, pp. 201-202, discussing Provider Exhibit P-1 "Agreement of Consolidation" ("And then subparagraph D talks about the CSJ and Ministry, have concluded that the interests of St. Joseph and St. Francis would be better served if they were to consolidate and become a multi-institutional, integrated regional health delivery system, which allows them to carry on their separate traditions, while enhancing their combined ability,….").

[40] The Administrator notes the court's ruling in *Via Christi Regional Medical Center, Inc., v. Leavitt*, 509 F.3d 1259 (10th Cir. Dec., 7, 2007), which involved the other party in same transaction as involved in this case. Therefore many of the factual findings in that case are also involved in this case. The Administrator is mindful that the Provider in this case may seek relief in either the same circuit as *Via Christi* or in the District of Columbia. The court ruled in *Via Christi* that the loss claimed by the provider in *Via Christi* was appropriately rejected by the Administrator, since the consolidation was not a bona fide sale. In Via Christi, the court stated, "We agree with the Secretary that, in order for consolidating Medicare providers to obtain reimbursement for a depreciation adjustment, the consolidation must meet the "bona fide sale" requirements of 42 C.F.R

bargaining, nor an attempt to maximize any sale price as would be expected in an arms' length transaction.[41] As stated above, a bona fide sale contemplates an arm's length transaction, between unrelated parties for reasonable consideration, with each party acting in its own self interest. As outlined in PM A-00-76, in evaluating whether a bona fide sale has occurred with respect to a merger or consolidation between or among nonprofit entities, a comparison of the sale price with the fair market value of the assets acquired is also required. A large disparity between the sale price (consideration) and the fair market value of the assets sold indicates the lack of a bona fide sale.

The Administrator finds that the record shows that the Provider never pursued any efforts to maximize gains upon the consolidation or "sale" of its assets and, hence, did not conduct a "bona fide" sale. For example, even the Board recognized that:

> [T]he record is clear that the Provider was not interested in selling its assets. Rather, the Provider saw a distinct need to establish a partnership with the health care industry to help assure their continued operation.[42]

In addition, in this case, the record shows that the Provider transferred hospital assets that were not appraised until almost 27 months after the consolidation was complete.[43] The Provider never adequately assessed the value of its assets before commencement with the consolidation. The record shows that the Provider's strategy for the consolidation focused on formation of an entity that would advance

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§413.134(f)." The *Via Christi* court held that "substantial evidence justified the Secretary's finding that no 'bona fide sale' occurred here. This was not an arm's length transaction. St. Joseph admitted that it was not attempting to get the full value for its assets, but rather its primary goal was to make a decision that would advance its ministry. The principals of St. Joseph did not approach any entity about a consolidation, and they rejected the idea of putting St. Joseph up for sale because of their desire to perpetuate Catholic health care ministry in the community." *See also, Robert F. Kennedy v. Leavitt*, 526 F.3d 557 (9th Circuit Court 2008) (*Robert F. Kennedy Medical Center*, 2005-D9) and the 3rd Circuit's affirmation of the Administrator's decision in Germantown Hospital, Admin. Dec. No. 2004-D36 (*See, Albert Einstein Medical Center, Inc. v. Sebelius*, Docket No. 07-3807, May 22, 2009, Medicare and Medicaid Guide (CCH) ¶302,889), where the courts have affirmed the "bona fide sale" rule.

[41] *See*, e.g., Provider Exhibit P-29 merger proposal report, Exhibit P-27, St. Francis letter dated February 21, 1994.

[42] Board decision at p.20.

[43] *See* Provider Exhibit 37.

their ministry, not maximize the proceeds received from selling its assets. The Provider was apparently not concerned about assessing whether the transaction was for reasonable consideration. Instead, much like its consolidation partner St. Joseph, it focused on transitioning its debts and assets to the new consolidated entity in order to better advance the Catholic health care ministry in the community. The Provider's witness further testified that:

> Q. And I understand you testifying that the decision to make this happen was not done at the hospital level but at the sponsor level…
> Q. That's correct.
> Q. And that they would not have considered the public sale, if you will, in the marketplace?
> A. That is correct.[44]

The absence of a calculation and determination of the value of the Provider's assets by the Provider before commencement of the transaction in order to ensure that such assets were transferred to St. Joseph for reasonable consideration, is also a strong indication that this transaction did not involve a bona fide sale. In addition, the length of time between the commencement of the transaction and the eventual conduction of the appraisal causes question of the validity of the appraisal.[45] Hence, the commencement of the transaction without any additional

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[44] Tr. 136-137.

[45] The revised calculations, based on the appraisal conducted by the Provider, showed that the appraiser used three methods. The "income" approach, adopted by the Board, determined the "fair market value of the assets as a total of $89 million including working capital of $58,757,000 and fixed assets and limited use assets of $110,759,000. *See* Exhibit P-37 at p. 123 as compared to the liabilities of "$212,000 (Exhibit P-101) The "income" approach placed a market value of approximately $30.565,000 on the depreciable assets that had a Medicare book value of approximately $148,000,000 based on financial statements. *See* Provider Exhibit P-37 at 123.

The appraisal also shows that using the "cost" approach to value the depreciable assets the land was valued at $3,773,000, land improvements at $4,475,360, building at $93,723,950 and equipment at $32,839,470 for a total of $134,820,780.

Using the "market" approach the appraisal showed a value of between $76,200,000 - $85,725,000 based on an approximate sale price of between $200,000-$225,000 per bed based on hospital sales for between $18,333, to $474,255 per bed from various States. Exhibit P-37 at 112-113. The appraisal did

evaluation of the value of the Provider's assets further support that the Provider was not involved in a transaction that involved bona fide bargaining at arms' length between well-informed parties, each acting in its own self interest.

Regarding the consideration, the record shows that the Provider exchanged assets with a total book value of $368 million for the assumption of approximately $214 million[46] in liabilities. As the Provider had not appraised the assets at the time of the transaction, the book value was the most obvious indicator of the assets' value at the time of the transaction. In particular, the Provider's work papers showed that the Provider transferred assets with, inter alia, the book value for current and cash assets of approximately $116,557,387,[47] plant and property equipment of approximately $148,044,951, deferred financing costs of approximately $18,918,981, Funds held in trust of $7,418,270 and Board designated funds[48] for

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not explain the basis for using the per bed figure and stated that value included the "net" working capital. The value would vary greatly dependent upon the per bed figure used.

It should also be noted that the appraisal uses a sale price of $181 million (not $214 million) as it would appear that using "net" working capital ($58 million) required it be reduced by current (etc.) liabilities (about $33 million) which also makes up the $214 million in "consideration." Therefore, it is not clear how the value of the depreciable assets would have been ascertained, if the working capital had not reflected the deduction for current liabilities and the sale price of $214 had been used. For example, the "market" value was between $76-85 million and the depreciable assets value was arrived at by backing out the working capital. If instead of $58 million, the working capital of $91 million ($58 working capital plus $33 million in current liabilities) were used, the depreciable assets would have been assigned no value ($79-85 million- $91 million = value of depreciable assets.) This same result would occur (no value) under the "income" approach (p.124), if the working capital had not reflected a reduction for current liabilities and the consideration amount of $214 million had instead been used as the sale price. In the least, it points to the questionable value of the appraisal and that the income or market approach does not have any easily seen relationship to the underlying value of the tangible depreciable assets.

[46] The Board adopted Provider Exhibit P-101 which showed the Provider's liabilities less PMA book value of $212, 327, 797. The "fair market value" of the assets is shown as $254,000,000.

[47] It is also not clear that the amount at issue in this case, involving the reimbursement impact of the loss claimed, was also included in any of the valuations.

[48] *See, e.g.,* Provider's Financial Statements, Exhibit P-36 and P-45. Exhibit P-36 also explained that the $79,063,027 described as "assets whose use is limited"

approximately $79,004,529, for a total of $369,964,118, all transferred for approximately $214,541,517 in liabilities. Thus, the Provider's assets were transferred for significantly less when a comparison of book value to liability assumption is used to evaluate the transaction. This significant difference between the "sale" price and the only contemporaneously determined valuation of the assets at the time of the transaction does not constitute reasonable consideration.

Even if one were to use the Valuation Counselors' appraisal conducted after the consolidation was completed and arranged by the consolidated entity[49] and not the Provider, the Administrator finds that the reproduction (replacement) cost approach is the only methodology that assigns a value to each individual asset which is necessary under the Medicare rules and, thus, is necessary for the determining of the fair market value of the various depreciable assets. The Administrator finds that the cost approach is the most appropriate methodology to use in establishing the fair market value of assets sold for the purpose of comparison with the sales price in a *bona fide* sale analysis. Moreover, the cost approach is generally viewed as the only reliable approach when dealing with special use properties or when there is a lack of market activity.[50] In contrast, the income approach relies upon an analysis of the predicted future income of the business enterprise as a whole without any regard to the individual and inherent value of the depreciable assets. As the Program Memorandum also explained, the

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includes assets set aside by the board of trustees for future capital improvements under a funded depreciation arrangement, over which the board retained control and assets held by trustees under indenture agreements and self-insured trust agreements.

[49] *See* January 21, 1997 Appraiser's letter to Via Christi, Exhibit P- 37.

[50] The Provider cites to a case suggesting that it demonstrates that the "income" approach is a better mirror of value. However, that case, *inter alia*, does not involve real property, or non-profit assets, or address the needs presented by the Medicare program that require the valuation of the individual depreciable assets, not a "business" valuation, which is by its methods is disassociated from any actual intrinsic value of the depreciable assets. Moreover, other cases including those involving this very issue have accepted the use of the cost approach. See e.g. *UPMC Braddock Hospital v. Leavitt*, 2008 WL 4442056 (W.D. Pa) (Sept 28, 2008)(looking at both the book value and the appraised fair market value using the cost approach.) *See also, e.g., Frazier V. US,* 79 Fed C1. 148, 176 (2007) ( "Because caselaw supports a view that the cost approach appraisal method is reliable and relevant and because plaintiffs have cited no specific flaws in how the cost approach method was employed here, the court finds that plaintiffs have not shown that the appraisals included in the prospectus undervalued plaintiffs permanent facilities.")

income approach[51] has minimal application in the non-profit sector because earnings are often understated due to charity care, pricing limitations, and government regulations, and the approach uses complex formulae that include some factors that are of questionable use in valuing non-profit entities (e.g., common stock risk premium).[52]

However, even the appraisal shows that, using the cost approach/depreciated reproduction value, the assets were valued at a total of $134,820,780 for tangible assets (land for $3,773,000, land improvements for $4,475,360, building for

[51] In this case the income approach appeared to use a discounting method-first projecting the business income stream over period of time based on the past revenues and determining a discount rate which reflected the risk, determining the residual or terminal business value at the end of the period and finally the present value. The accuracy of determining the value of a business, much less the underlying depreciable assets using this method are on view in this case. While the Provider argues that the $5 million annual revenue that formed the basis for the "income" approach was accurate, even in hind sight, the Provider's revenue for 1994 and 1995 rose to $15 and $24.8 million, respectively. *See* Provider Exhibit P-95; Tr. at 60, 70. The Provider argues that the consolidated entity's revenues subsequently dropped, supporting the income value and insisted that it was due to cardiac surgery competition. However, it also coincided with the consolidation and, thus, could also raise reasonable doubt as to the initial success and cost cutting advantages of the consolidation, which is the dominating event that occurred at that time. Regardless of the reasons for the swings in revenue, the swings also demonstrate the difficulties of valuing a business based on projections of future income. While the "market" approach was also used, comparing hospital sales, in order to support the value determined by the "income" approach, the "market" approach in turn noted, regarding its own methodology, that "comparability" is virtually impossible to ascertain.

[52] *See* Exhibit P-37 ("Under the market and income approaches to valuation, the underlying value of the operating tangible assets can be represented by analysis of earnings … However neither of these methods provide discrete indication of value for the individual asserts appraised…." The income approach (P-37 at 119-123), valued the business, not the assets, for a total of $89 million (a sum of "interim cash flows" and "terminal value" including working capital of $58,757,000 and not including limited use assets of $110,759,000. *See* Exhibit P-37 at p. 123. The appraiser placed, by "backing out" monetary and non-operating assets, the market value of the depreciable assets of $30.565.000. *Id.* at 123. It should also be noted that the appraisal uses a sale price of $181 million (not $214 million) as it would appear the net working capital ($58 million) was already reduced by liabilities that make up the "consideration."

$93,723,950 and equipment for $32,839,470), which, when combined with the current and cash assets ($116,577,387) and board designated funds (approximately $84 million) totaled more than $100 million in excess of the transfer price.[53] The transfer occurred for approximately 60 percent of the value of all the assets or approximately the value of the non-depreciable assets (cash, current and noncurrent assets) of the Provider. Consequently, the record shows that depreciable assets were in essence transferred for no or insignificant consideration.

Since there was a significant disparity of consideration tendered in exchange for the Provider's assets, the transaction in essence amounted to a combination ("consolidation") between the two parties, rather than a bona fide sale of assets.[54] In sum, as noted above a bona fide sale must be for reasonable consideration. There is no documentation in the record demonstrating that the Provider concluded that the assumption of debt was fair consideration for the Provider's assets. Thus, the Administrator finds that the transaction was not a bona fide sale as required under the regulations and PRM for the recognition of a loss on the disposal of assets.

Finally, as a loss cannot be allowed in this case, the Administrator does not reach the issue of how to calculate the loss. However, a review of the Board's decision on this issue highlights the anomalous results of finding that a loss is to be calculated in this case when there has been no bona fide sale. The Administrator concludes that this further supports a finding that no loss is to be calculated under

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[53] *See* also Stipulation Exhibit B, which also sets out the value of the nondepreciable assets, however, for the purpose of comparing fair market value with "sale price", it is important to note that the "net" working capital used already includes deductions of certain liabilities (consideration) that make up the $214,614,617. Note 6 of Stipulation Exhibit B. *See also.* P-36 Provider Financial Statement (note also that the cash and current equivalents in this document also shows about a $20 million more than Exhibit B.)

[54] The new post-consolidated entities reported the transaction on its financial statement as a pooling of interest under APB No. 16 (i.e.. continuation of ownership) and the Provider did not report a loss on its financial statements See e.g., Administrator decision in St Joseph n. 32 citing to Exhibits I-18, I-22, I-23, I-24 and Exhibit P-57 where consultant explains that the proposed affiliation would comprise a pooling of interests described "as the uniting of business interest of two or more companies … Ownership interests continue and the former basis of accounting shall be retained." *See* St. Francis record at Provider Exhibit P-42, Via Christi Medical Center Financial Statements, p. 6. "The consolidation of St. Joseph and St. Francis has been accounted for in a manner similar to the pooling of interests…."

the facts of this case. If one were to assume that the assumption of liabilities would be the basis for any loss, the Board recognized that a well run and performing hospital corporation may well experience a greater "loss" on depreciable assets, than the poor performing hospital corporation. As reflected in the Board's own analysis, the Administrator finds that there is an obvious flaw in finding this consolidation constituted an event requiring application of a loss methodology that is applied to bona fide sales, where, in fact, there has not been a bona fide sale.[55] There is no explicit regulatory directive applying a special rule for consolidation of non-profits that rewrites the related party rules, the loss on sale rules, or the rules controlling the calculation of a loss that would allow this end result proposed by the Board.

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 CFR §413.134(f) and that the Providers failed to meet any of the other criteria of paragraph (f) that would allow the calculation of a "loss on consolidation."

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

## 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: 9/01/09

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