CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Marian Medical Center **Provider** **vs.** **Blue Cross Blue Shield Association/ National Government Services (n/k/a First Coast Service Options-California** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 04/23/97** **Review of:** **PRRB Dec. No. 2011-D7** **Dated: November 03, 2010**

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 Center for Medicare, Centers for Medicare and Medicaid Services submitted comments, concurring with the decision rendered by the Board but disagreed on the Board's conclusion that the regulation barred the application of the related party concept, to the merging parties' relationship post merger. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. No comments were received from the Provider. 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 a loss on disposal of assets is required to be recognized by Medicare as a result of the April 24, 1997 statutory merger of the Provider.

The Board held that the Intermediary's adjustments disallowing the Provider's claimed loss on the disposal of assets was proper. The Board determined that the

transaction was not a *bona fide* sale as required under the regulations and Provider Reimbursement Manual (PRM) for the recognition of a loss on the disposal of assets. The Board found that 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.

With respect to the related party issue, the Board found that the parties to the transaction were not related. Nevertheless, the Board commented and held that, the regulation barred the application of the related party principle to the merging parties' relationship to the surviving entity. The Board concluded that the related party concept only applied to the entities relationship that existed prior to the merger.

Next, with respect to the *bona fide* sale requirement, the Board held that the Provider's statutory merger was not a *bona fide* sale. In reaching this determination the Board relied on *Robert F. Kennedy Medical Center v. Leavitt*, Case No. CV 05-1628 AG (CD Ca Sept. 21, 2006), *aff'd*, 526 F.3d 557 (9th Cir. May 19, 2008) (hereinafter, *Kennedy*). In *Kennedy*, the 9th Circuit Court of Appeals held that a comparison of the sale price with the fair market value (FMV) of the assets acquired was required. A large disparity between the sale price (consideration) and the FMV of the assets sold indicated a lack of reasonable consideration and, hence, the lack of a *bona fide* sale. In this case, the Board found that the Provider did not receive "reasonable compensation" for its assets. Accordingly, the merger was not a *bona fide* sale and the loss on disposal of assets was not allowable.

SUMMARY OF COMMENTS

CM submitted comments concurring with the decision rendered by the Board but disagreed on the Board's conclusion that the regulation barred the application of the related party concept, to the merging parties' relationship post merger. CM asserted that the applicability of the related party analysis is applicable to the relationship between the parties pre and post merger. As such, the Intermediary can review the relationship between the parties according to the subsequent rights created by their contract post merger.

No comments were received by the Provider.

DISCUSSION

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

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

I. Medicare Law and Policy -- Reasonable Costs.

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

A. Capital Related Costs.

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

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

---

[1] Pub. Law 98-21.

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

1. Depreciation.

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

> Medicare reimburses providers for the direct and indirect costs necessary to the provision of patient care, including the cost of using assets for inpatient care. Thus, depreciation of those assets has always been an allowable cost under Medicare. The allowance is computed on the depreciable basis and estimated useful life of the assets. When an asset is disposed of, no further depreciation may be taken on it. However, if a gain or loss is realized from the disposition, reimbursement for depreciation must be adjusted so that Medicare pays the actual cost the provider incurred in using the asset for patient care.[3]

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

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

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

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

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

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

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

> The revision would describe the various types of disposal recognized under the Medicare program, and would provide for the proper computation and treatment of gains and losses in determining reasonable costs. [4]

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

> Existing regulations contain a requirement that any gain or loss realized on the disposal of a depreciable asset must be included in Medicare allowable costs computations… The regulations, however, specify neither the procedures for computation of the gain or loss nor the methods for making adjustment to depreciation. These amendments provide the rules for the treatment of gain or loss depending upon the manner of disposition of the assets. [5] (Emphasis added.)

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

> (1) *General*. Depreciable assets may be disposed of through sale, scrapping, trade-in, exchange, demolition, abandonment, condemnation, fire, theft, or other casualty. If disposal of a depreciable asset results in a gain or loss, an adjustment is

---

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

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

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

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

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

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

> A bona fide sale contemplates an arm's length transaction between a willing and well informed buyer and seller, neither being under coercion, for reasonable consideration. An arm's length transaction is … negotiated by unrelated parties, each acting in its own self interest.[6]

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

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

---

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

Paragraph (f)(3) addresses gains or losses realized from sales within 1 year after the provider terminates from the program, while §413.134(f)(4) addresses exchange trade-in or donation[7] of the asset stating that: "[g]ains or losses realized from the exchange, trade-in, or donation of depreciable assets are not included in the determination of allowable cost." Finally, paragraph (f)(5) explains that the treatment of gains and losses when there has been an abandonment (permanent retirement) of the asset, and paragraph (f)(6) explains the treatment when there has been an involuntary conversion, such as condemnation, fire, theft or other casualty.

2. Revaluation of Assets.

Historically, as reflected in the regulation, the disposal of a depreciable asset used to render patient care may result in two separate and distinct reimbursement events: 1) the calculation of a gain or loss for the prior owner and 2) a revaluation of the depreciable basis for the new owner. While the determination of gains and losses is generally only of interest to the prior owner,[8] the new owner in the same transaction is interested in the determination of when Medicare will allow the revaluation of depreciation for purposes of calculating the new owner's depreciation expense.

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

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

****

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

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

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

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

(i) *Statutory merger between unrelated parties*. If the statutory merge is between two or more corporations that are unrelated (as specified in §413.17), the assets of the merged corporation(s) acquired by the surviving corporation may be revalued in accordance with paragraph (g) of this section. <u>If the merged corporation was a provider before the merger, then it is subject to the provisions of paragraphs (d)(3) and (f) of this section concerning recovery of accelerated depreciation and the realization of gains and losses</u>. The basis of the assets owned by the surviving corporation are unaffected by the transaction. An example of this type of transaction is one in which Corporation A, a nonprovider, and Corporation B, the provider, are combined by a statutory merger, with Corporation A being the surviving corporation. In such a case the assets of Corporation B acquired by Corporation A may be revalued in accordance with paragraph (g) of this section.

(ii) *Statutory merger between related parties*. If the statutory merger is between two or more related corporations (as specified in §413.17), no revaluation of assets is permitted for those assets acquired by the surviving corporation. An example of this type of transaction is one in which Corporation A purchase the capital stock of Corporation B, the provider. Immediately after the acquisition, of the capital stock of Corporation B, there is a statutory merger of Corporation B and Corporation A, with Corporation A being the surviving corporation. Under these circumstances, at the time of the merger the transaction is one between related parties and is not a basis for revaluation of the provider's assets.

B. Related Organizations

The regulation at 42 C.F.R. § 413.134 references the related organization rules at 42 C.F.R. § 413.17. The regulation at 42 C.F.R. § 413.17, states, in pertinent part:

> (b) *Definitions. (1) Related to the provider*. Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.
> (3) *Common ownership*. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.
>
> (4) *Control*. Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

Consistent with the Act and the regulations, the above principles are set forth in the Provider Reimbursement Manual (PRM), which provides guidelines and policies to implement Medicare regulations for determining the reasonable cost of provider services. In determining whether the parties to a transaction are related, the PRM at § 1004, et seq., establishes that the tests of common ownership and control are to be applied separately, based on the facts and circumstances in each case. With respect to common ownership, the PRM at § 1004.1 states:

> This rule applies whether the provider organization or supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or nonprofit. In the case of nonprofit organization, ownership or equity interest will be determined by reference to the interest in the assets of the organization (e.g., a reversionary interest provided for in the articles of incorporation of a nonprofit corporation).[10]

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:

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

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

The related party organization was further explained in HCFA Ruling 80-4 which adopted the Eighth Circuit Court of Appeals' decision in Medical Center of Independence v. Harris, 628 F.2d 1113 (8th Cir. 1980).[11] 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.

---

[11] In Medical Center of Independence v. Harris, supra, the court held that a medical center and a management corporation from which it leased and operated a hospital facility were related organizations within the meaning of 42 C.F.R. §413.17, where the management corporation had purchased the assets of the hospital and had entered into a 15 year lease agreement with the hospital, with a management agreement to run concurrently with the lease, and where six employees of the management corporation were elected as directors of the hospital, and two were elected as hospital officers. The court upheld the district court's finding that the management corporation had the power, directly or indirectly, significantly to influence or direct the actions or policy of the hospital, and rejected a contention that potential influence, in the absence of a past and present exercise of influence, is insufficient to warrant a finding of control. The court stated that, while the absence of any prior relationship between the parties is relevant to the issue of control, it should not automatically lead to the conclusion that the related party principle does not apply.

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

1. Program Memorandum A-00-76.

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

The PM also noted that, unlike for-profit mergers or consolidations, which often involve a dispatching of the former governing body and/or management team, many non-profit mergers and consolidations involve the continuation, in whole or part, of the former governing board and/or management team. Thus, in applying the related organization principles of 42 C.F.R. § 413.17, CMS stated that consideration must be given to whether the composition of the new board of directors, or other governing body and/or management team include significant representation from the previous board or management team. If that is the case, no real change of control of the assets has occurred and no gain and loss may be recognized as a result of the transaction. This PM A-00-76 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 A-00-76 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:

> [W]hether 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.

PM A-00-76 stated that the term significant, as used in PM A-00-76 has the same meaning as the term significant or significantly, in the regulations at 42 C.F.R.

413.17 and the PRM at Chapter 10. Important considerations in this regard include that the determination of common control is subjective; each situation stands on its own merits and unique facts; a finding of common control does not require 50 percent or more representation; there is no need to look behind the numbers to see if control is actually being exercised, rather the mere potential to control is sufficient.

Notably, the Administrator finds that the requirement that the term “between related organizations” include an examination of the relationship before and after a transaction of assets under 42 CFR §413.417[12] was applied as early as 1977 by the agency in evaluating whether accelerated depreciation would be recaptured. The agency decided that “when the termination of the provider agreement results from a transaction between related organizations and the successor provider remains in the health insurance program and its asset bases are the same as those of the terminated providers, health insurances reimbursement is equitable to all parties”: thus, the depreciation recovery provisions would not be applied.[13] The agency looked specifically at whether, in a related party transaction, the control and extent of the financial interest remained the same for the owners of the provider before and after the termination.[14] Thus, PM A-00-76 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 not inconsistent with the language of 42 CFR 413.134(1)(3)(ii) that refers to “between two or more corporations that are

---

[12] Originally codified at 42 C.F.R. § 405.427

[13] 42 Fed. Reg. 45897 (1977).

[14] 42 Fed. Reg. 45897, 45898 (September 15, 1977) (Recovery of excess cost resulting from the use of accelerated depreciation when termination of provider agreement results from transaction between related organizations.)

related" with respect to proprietary corporations. CMS has always recognized a 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 reasonably applies the related parties' rules in requiring an examination of the relationships of the consolidating corporations and the newly created corporation.

In addition, the PM stated that many non-profit mergers and consolidations have only the interests of the community at large to drive the transaction. This community interest does not always involve engaging in a bona fide sale or seeking fair market value of assets given. Rather, the assets and liabilities are simply combined on the merger/consolidated entities books. The merged/consolidated entity may or may not record a gain or loss resulting from such a transaction for financial reporting purposes. However, notwithstanding the treatment of the transaction for financial accounting purposes, no gain or loss may be recognized for Medicare payment purposes unless the transfer of the assets resulted from a *bona fide* sale as required by the regulation at 42 C.F.R § 413.134(l) and as defined in the PRM at § 104.24. The PM stated that the regulation at 42 C.F.R. § 413.134(l) does not permit a gain or loss resulting from the combining of multiple entities' assets and liabilities without regard to whether a *bona fide* sale occurred. The PM stressed that a *bona fide* sale requires an arm's length business transaction between a willing and well-informed buyer and seller. This also requires the analysis of the comparison of the sales price with the fair market value of the assets acquired as reasonable consideration is a required element of a bona fide sale. 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."[15]

In determining reasonable consideration, the PM stated that:

> Appraisals may be relied on to establish the fair market value of depreciable assets. (See PRM §134ff.) However, caution must be taken in evaluating the appropriateness of the valuations established by appraisal for the purpose of this comparison.
>
> The three most common valuation methodologies are the "cost approach," the "market approach," and the "income approach." A single appraisal may use one or more of these methodologies to arrive at a valuation of the entity. The cost is the only methodology that

---

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

> produces a discrete indication of the value for the individual assets of the business, and thus, is the approach that is used to allocate a lump sum sales price among the assets sold. (See 42 CFR 413.134(f)(2)(iv).) The market approach produces an estimate of value by comparing the entity being valued to sales of similar businesses. The income approach produces a valuation through analysis of the predicted future stream of income. Both the market approach and the income approach produce a valuation of the business enterprise as a whole, without regard to the individual fair market values of the constituent assets. As a result, both the market approach and the income approach could produce an entity valuation that is less than the market value of the current assets. Moreover, the income approach has minimal application in the non-profit sector because 1) earnings are often understated due to charity care, pricing limitations, and government regulations, and 2) the approach uses complex formulae that include some factors that are of questionable use in valuing non-profit entities (e.g., common stock risk premium). For the foregoing reasons, the cost approach is the most appropriate methodology to be used in establishing the fair market value of the assets sold for the purpose of comparison with the sales price in a bona fide sale analysis.[16]

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

2. The Intermediary CHOW Manual and APB No. 16.

The Intermediary Manual, Chapter 4000, et seq., also addresses changes of ownership (CHOW) for purposes of Medicare certification and reimbursement. These sections provide guidelines based on Medicare law, regulations and implementing instructions for use by the Medicare intermediaries and providers on the reimbursement implications of various types of changes of provider

---

[16] Id. at 4.

organizations transactions or CHOWs. Section 4502 explains that the first review of a CHOW transaction is to determine the provider structure both before and after the transaction and to determine the type of transaction which occurred because Medicare has developed specific policies on the reimbursement effect of various types of CHOW transactions which may be different from treatment under generally accepted accounting principles or GAAP. Section 4502.1, list the various types of provider organizational structures and included as one possible type of provider organization are Corporations.

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

Among the various types of provider structures and transactions recognized by Medicare are mergers, consolidations, and corporate reorganizations at § 4502. Section 4502.6, describes a statutory merger as the combination of two or more corporations pursuant to the laws of the state involved, with one of the corporations surviving the transaction. Medicare program policy permits a revaluation of assets acquired in a statutory merger between unrelated parties, when the surviving corporation is a provider. Notably, Medicare policy at § 4502.10 does not permit a revaluation of assets affected by a "reorganization" of a corporate structure. All such transactions are considered among or between related parties. As an example the Intermediary Manual explains that:

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

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

Section 4508.11 of the Intermediary Manual,[17] in addressing stock corporations states that, Medicare program policy places reliance on GAAP, as expressed in APB

---

[17] Section 4504.1 states that: "where Medicare instructions are silent as to the valuation of consideration given in an acquisition, rely upon generally accepted

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

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

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

This policy of not recognizing a gain or loss when the transaction is between related parties, whether it constitutes a reorganization, consolidation or merger, is also consistent with Internal Revenue Service (IRS) rules on the non-recognition of a gain or loss when a statutory reorganization has been determined to have occurred. Relevant to this case, while the Medicare rules may diverge from IRS rules and Medicare policy is not bound by IRS policy, IRS policy often reflects rationale underlying the establishment of similar policies under Medicare.[19] In fact, in setting

---

accounting principles. APB No. 16 discusses valuation methods of consideration given for assets acquired in business combinations."

[18] 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).

[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).

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 merger are not mutually exclusive terms under IRS rules. Medicare policy similarly indicates that they are not mutually exclusive terms under Medicare rules. That is, consolidations and mergers may in fact constitute in essence, reorganizations and reorganizations may involve more than one corporation.[21] For example, a merger where the predecessor corporation board continues significant control in the new corporation board is treated the same as a reorganization for Medicare reimbursement purposes and no gain or loss is recognized. However, for example, where the predecessor corporation board does not continue significant control in the new corporation board, a gain or loss will be recognized for Medicare reimbursement purposes.

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

---

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

> 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 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

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

[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.)

[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)).

> important non-tax reasons for sales between related parties, so it's important to fairness to preserve the pre-sale basis where loss on the sale itself isn't recognized for tax purposes. Otherwise the statute would be a heads-I-win, tails-you-lose provision for the IRS: the seller can't take the loss, but the IRS calculates the buyer's gain on resale using the lower basis.

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

II. Finding of Facts and Conclusion of Law.

The Provider was a general acute care hospital located in Santa Maria, California. Prior to the merger on April 24, 1997, the Provider was owned and operated by the sisters of St. Francis of Penance and Christian Charity, St. Francis Province, a province of an international Franciscan congregation (Sisters of St. Francis) (the Sponsor).[25] Mercy Healthcare Ventura County (Mercy) was a two hospital system consisting of St. Johns Regional Medical Center and Pleasant Valley Hospital. Catholic Healthcare West (CHW) was the sole corporation member of Mercy.[26] CHW was co-sponsored by several catholic women's religious orders and oversees and coordinates the activities of a health care system of over 30 acute hospitals in California Arizona and Nevada. The Provider, CHW and Mercy entered into an Agreement of Merger creating CHW Central Coast (CHW-CC) on March 15, 1997.[27] Effective April 24, 1997, the Provider, CHW and Mercy entered into a statutory merger pursuant to Chapter 10 of the California Nonprofit Corporation law, with Mercy, renamed CHW-CC, remaining as the surviving corporation. Under the merger agreement, CHW-CC, the surviving corporation, assumed the Provider's liabilities.[28] The assumption of the Provider's liabilities was the sole consideration

---

[25] Provider's Post Hearing Brief at 3.
[26] Id.
[27] . Provider's Exhibit P-1
[28] Id. at 7, paragraph 3.7.3.

for the transaction, initially estimated to be $36.7 million and lowered to $32.7 million.[29] This was allocated among the Provider's assets as set forth in the Purchase Price Allocation Agreement.[30]

The merger agreement provided that the Sisters of Saint Francis will become a non-member sponsor of CHW with all the rights and responsibilities as are granted to non-member Sponsors under the CHW governance. A unique provision of the merger agreement provided that "Under canon law the Sisters of St Francis shall retain its Canonical Stewardship with respect to its Ecclesiastical Property. Alienation, within the meaning of Canon Law, of property considered stable patrimony will not occur at the time of the closing as a result of any contributions made by the Sisters of St Francis though and pursuant to this agreement. The Sisters of St Francis in accordance with the reserved rights set forth in the CHW Governance matrix have the right to approve any actions that constitute an alienation of the Ecclesiastical Property contributed by the Sisters of St Francis including without limitation the sale, lease mortgage or encumbrance of the Santa Maria campus facilities." The Santa Maria Campus" was referring to the heathcare facilities and related operation in Santa Maria California presently operated by or affiliated with Marian Medical Center.

Applying the statute, regulations, PRM and CMS policy to the facts of this case, the Administrator agrees with the Board's determination that the transaction was not a *bona fide* sale as required under the regulations and PRM for the recognition of a loss on the disposal of assets. The Board found that the Provider did not receive "reasonable compensation" for its assets. In the *bona fide* sale, context, the reasonable consideration inquiry involves determining whether the provider received fair market value for its assets. The Board found that the Provider did not receive "reasonable compensation" for its assets because the criteria the Provider used to select an organization to merge with did not consider obtaining a fair price for its assets. Instead, the Provider accepted the assumption of its debts as the sale price without the negotiations of an arm's length transaction. The Board correctly determined, and herein adopted, that the Provider did not attempt to obtain a fair market value price for its assets because the criteria it used to select a merger partner did not take into consideration obtaining fair market value for its assets, but instead considered the value of such non monetary factors as maintaining its religious mission of the faculty.

---

[29] Provider's Exhibit P-6. Subsequent review determined that the amount of assumed liabilities was approximately $32.7 million

[30] Id.

The regulations at 42 C.F.R. § 413.134(f)(2)(iv), with respect to assets sold for a lump sum, specifies the following:

> 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 the sale.

The Administrator finds that based on the plain language of the regulation, the reproduction (replacement) cost approach is the only methodology that assigns a value to each individual asset vs. an allocation of an assigned value by an appraiser to each asset. In this case the record shows that the consideration received by the Provider was assumed liabilities of approximately $32.7 million.[31] For this consideration, the surviving entity, received cash and cash equivalent assets worth approximately $15.9 million,[32] plus plant and equipment appraised at $51.1 million under the cost approach.[33] The Administrator finds that when the cost approach is used, (and as explained in the PM it is the only appropriate method to use under Medicare rules), the FMV of the Provider's assets totaled $67 million. When compared with the consideration received of $32.7 million, the Provider did not receive reasonable consideration for the assets transferred. As stated above, "a large disparity between the sale price (consideration) and the fair market value of the assets sold indicates the lace of a *bona fide* sale. In sum, the Administrator concurs with the Board's determination that the Provider is not entitled to reimbursement for a loss on disposal of assets because the Provider failed to demonstrate that the merger was a *bona fide* sale.

However, the Administrator does not agree with the Board's determination that the regulation bars the application of the related party principle to the merging parties' relationship to the surviving entity. The Board incorrectly concluded that the related party concept only applied to the entities relationship that existed prior to the merger. The Administrator holds that the related party principle applies to the parties' relationship pre and post merger. The Administrator finds that the related party organization was previously explained in HCFA Ruling 80-4 which adopted the Eight Circuit Court of Appeals decision in *Medical Center of Independence v. Harris*.[34] The Court in *Medical Center* pointed out that the applicability of the

---

[31] Tr. at 181 and Provider's Exhibit 12

[32] Id.

[33] Provider's Exhibit P-8 at 92. In addition, the loss on disposal of assets Medicare reimbursement was calculated as worth approximately $8 million.

[34] 628 F.2d 1113 (8th Cir. 1980).

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 court in *Medical Center* asserted that the applicability of the related party rule is also determined by considering the relationship between the parties according to their subsequent rights created by their contract. The terms of the contracts and events which occurred subsequent to the execution of the contract in that case had the effect of placing the provider under the control of the supplier. This principle was also reflected in the PM analysis of the related party principle in the context of a merger or consolidation, where there is evidence of the continuity of control or ownership by the pre-merger parties of the post transaction entity. Accordingly, the Administrator finds that the relevant consideration to the related party analysis would include whether the parties were related prior to and after the merger.

In this case, the record is lightly developed with respect to whether the Provider (and or related Sponsor) was related to the merged entity through a continuity of control and ownership.[35] However, among other things the record does show that the Provider's Sponsor continued as the nonmember sponsor in the surviving entity and also retained its "Canonical Stewardship with respect to its Ecclesiastical Property;' that is; it retained the right to approve any actions that "constitute an alienation of the Ecclesiastical Property contributed by the Sisters of St Francis including without limitation the sale, lease mortgage or encumbrance of the Santa Maria campus facilities." At the oral hearing, the Provider's witness suggested it was only the living quarters involved, but on its face, the actual language is much broader to include the health care facilities. The Provider's witness agreed that a California court would respect a contract provision between two catholic contractors to apply cannon law to a particular real estate issue.[36] Such a provision shows a continuing ownership influence of some extent over the real property.

The Provider's Sponsor also continued to receive a disbursements, as a sponsorship fee, based on the budgeted operating expense of the Provider, Marian Medical Center and the sisters were to provide direct services to the surviving entity. The presence of one former Board member out of 16 voting members (18 total members) would not indicate a large presence of the Provider, but the Provider Exhibit 4 shows that 4 members of the 18 total members were appointed by Provider. The merger consisted of the provider and two other hospital entities, which had CHW as the umbrella organization (which itself was a large health system made up of 30 hospitals). Accordingly, the Provider's representation on the board of 25 percent of

---

[35] For example there is no evidence of pre and post merger management teams of the Provider and membership of the Sponsor pre and post merger.

[36] Tr. 121.

voting members would reflect a proportional influence. The Agreement of Merger document at Section 4.1 shows that St Francis and Marian Medical had a significant proportional ability to put forward Board members than the board representation of one former board member reflects. The record also shows a promissory note for "value received" obligating the Provider (signed by the Provider's VP Fiscal Service. prior to the merger) to pay Mercy Health Care (the surviving entity) $25,000,000, which the Provider explained was the refinancing of the Provider's debt, such that the purchaser of the assets (the surviving entity) was the holder of the debt instrument that made up the "consideration." The foregoing,, inter alia, are all indications of a related party relationship to a certain extent pre-merger (in the promissory note) and to a larger extent post merger through the continued control of the real property, the continuing proportional representative on the board of directors and the receipt of the sponsorship fees. Finally the record shows that, for financial purposes, the transaction was treated as a pooling of interests, which again is consistent with some continuity of ownership interest by the provider and its related party Sponsor.

DECISION

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

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

Date: 1/4/2011 /s/
Marilyn Tavenner
Principal Deputy Administrator and Chief Operating Office
Centers for Medicare & Medicaid Services