PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D52

PROVIDER -
North Iowa Medical Center
Mason City, Iowa

Provider No. 16-0059

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Wellmark Blue Cross and Blue Shield of
Iowa

DATE OF HEARING-
December 2, 1999

Cost Reporting Period Ended -
June 30, 1993

CASE NO. 96-2570

INDEX

ISSUE:

Was the Intermediary=s adjustment disallowing the Provider=s loss on the sale of its assets proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

North Iowa Medical Center (AProvider@) was a 75-bed, general short-term acute care hospital located in Mason City, Iowa.[1] On June 11, 1993, the Provider entered an agreement with North Iowa Mercy Health Center, Inc. (ANIMHC@) whereby substantially all of the Provider=s assets were sold to NIMHC.[2] Thereafter, the Provider submitted its final Medicare cost report in which it claimed a loss on the disposal of its assets. Wellmark Blue Cross and Blue Shield of Iowa (AIntermediary@) reviewed the Provider=s cost report and determined that the sales transaction occurred between related parties. On that basis, the Intermediary denied the Provider=s claimed loss and reflected an adjustment to that effect in a Notice of Program Reimbursement dated April 30, 1996. On September 11, 1996, the Provider appealed the Intermediary=s adjustment to the Provider Reimbursement Review Board (ABoard@) pursuant to 42 C.F.R. '' 405.1835-.1841, and met the jurisdictional requirements of those regulations. The amount of program funds in controversy is approximately $3,256,187.[3]

The Provider was represented by Chris Rossman, Esq., and William S. Hammond, Esq., of Honigman Miller Schwartz and Cohn. The Intermediary was represented by James R. Grimes, Esq., Associate Counsel, Blue Cross and Blue Shield Association.

BACKGROUND:

Prior to the subject sales transaction, the Provider was a non-profit corporation which owned and perated an acute care hospital and other health care facilities located in Mason City, Iowa. The Provider was also the sole member of the North Iowa Medical Center Foundation (AFoundation@). During this same period, Sisters of Mercy Health Corporation (ASMHC@), a Michigan non-profit corporation, also owned and operated an acute care hospital and other health care facilities in Mason City, through an unincorporated division, St. Joseph Mercy Hospital (ASJMH@).[4]

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1 Intermediary Position Paper at 3.

2 Provider Position Paper at 1. Exhibit P-B.

3 Provider Position Paper at 2.

4 Provider Position Paper at 1. Transcript (ATr.@) at 9-13.

On November 19, 1992, the Provider entered a Memorandum of Understanding (AMOU@) with SMHC and SJMH whereby the parties agreed to work towards a Alegal consolidation.@ In part, the MOU explains the parties= agreement to form a new corporation, Mason City Healthcare, Inc. (AMCH@), to operate the then current campuses of the Provider and SJMH under the governance of SMHC. Additionally, the MOU explains that the Foundation will not be part of the consolidation. The Foundation will, however, be a member of MCH with limited powers, and with MCH being the recipient of all funds raised by the Foundation.[5]

On February 18, 1993, SMHC incorporated MCH, a Delaware non-profit corporation for the purpose of acquiring the Provider=s assets. On or about June 21, 1993, MCH changed its name to North Iowa Mercy Health Center, Inc.[6]

At the time of incorporation, there were two members of NIMHC. The Foundation was the Class A member and SMHC was the Class B member. In all, the Foundation (as the Class B member) was granted limited powers which included a percentage of the net assets of NIMHC upon its dissolution, while SMHC was given substantial control over NIMHC. In part, SMHC was granted the power to (i) approve and initiate appointment and removal of NIMHC's chief executive officer (ACEO@); (ii) approve and initiate amendments to NIMHC's governance documents; (iii) approve and initiate ratification or amendment of NIMHC's philosophy, mission, role and goals; (iv) approve or initiate encumbrance of NIMHC's assets and incurrence by NIMHC of long-term debt and short-term debt in excess of $500,000; (v) approve and initiate acquisition or disposition of assets of NIMHC in excess of $500,000 and (vi) approve and initiate dissolution of NIMHC.[7]

On June 11, 1993, the Provider and NIMHC entered into a Purchase Agreement providing for the sale of substantially all of the Provider's assets to NIMHC, including the acute care hospital and other health care facilities owned and operated by the Provider. In exchange for the acquired assets, NIMHC agreed to assume certain liabilities of the Provider totaling $7,015,100.
According to the Provider, the Purchase Agreement details the specific assets being purchased and the specific liabilities being assumed by NIMHC, and contains standard representations and warranties of a seller with respect to corporate status, tax exempt status, and financial status, etc.[8]

On June 24, 1993, two weeks after the execution of the Purchase Agreement, SMHC appointed 4

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5 Intermediary Position Paper at 7. Exhibit I-5.

6 Provider Position Paper at 1.

7 Id. See also Exhibit P-A at 5-9.

8 Id. Exhibit P-B.

members of the 20 member Board of Trustees of the Provider to be members of the 18 member Board of Trustees of NIMHC. In addition, the President of the Provider became an Executive Vice President and the Chief Regional Systems Officer of NIMHC. In this position, he reported to the CEO of NIMHC, who was formerly the CEO of SJMH.[9]

PROVIDER=S CONTENTIONS:

The Provider contends that the loss it incurred on the sale of its depreciable assets is properly included in the determination of its Medicare reimbursement. The loss resulted from a bona fide sale. Accordingly, the Intermediary=s adjustment is improper.[10]

The Provider contends that a loss realized from a bona fide sale of depreciable assets is included in the determination of allowable Medicare costs pursuant to 42 C.F.R ' 413.134(f). A sale of depreciable assets is bona fide if (i) fair market value is paid for the assets, and (ii) the sale is negotiated at arm's length between unrelated parties. Parties are related if they share either common ownership or common control. 42 C.F.R ' 413.17; Eastland Memorial Hospital v. Blue Cross and Blue Shield of Texas, PRRB Dec. No 96-D37, June 20, 1996, Medicare and Medicaid Guide (CCH) & 44,789, decl=d rev., HCFA Administrator, July 22, 1996. Whether common control or common ownership exists must be determined on a case-by-case basis, based upon an examination of the facts and circumstances unique to the particular transaction. Provider Reimbursement Manual, Part I (AHCFA Pub. 15-1@)'' 1004.1 and 1004.3. Common control exists where one party has the power, directly or indirectly, significantly to influence or direct the actions or policies of the other. 42 C.F.R ' 413.17(b)(3); HCFA Pub. 15-1 ' 1002.3. Common ownership exists where an individual or individuals possess significant ownership or equity in both parties, or if either party owns a significant interest in the other. 42 C.F.R ' 413.17(b)(2); HCFA Pub. 15-1 ' 1002.2.

With respect to these rules, the Provider contends that it was paid the fair market value of its assets.[11] In exchange for the acquired assets, NIMHC assumed certain liabilities of the Provider totaling

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[9] Provider Position Paper at 2.

[10] Provider Position Paper at 3.

[11] Id.

$7,015,100. This amount is consistent with the fair market value of the acquired assets ($7,400,000) as determined by Valuation Counselors Group, Inc., an independent, reputable appraiser, experienced in valuing real property, facilities and related assets used in the delivery of medical care and treatment. Moreover, the appraiser performed its analysis consistent with applicable Medicare regulations defining fair market value as Athe price that the asset[s] would bring by bona fide bargaining between well informed buyers and sellers at the date of acquisition.@ 42 C.F.R. ' 413.134. Thus, in preparing its valuation, the appraiser adopted the following definition of the term Amarket value:@

> [t]he most probable price which a property should bring in a competitive and open market under all conditions requisite to a fair sale, the buyer and seller each acting prudently and knowledgably, and assuming the price is not affected by undue stimulus. Implicit in this definition is the consummation of a sale as of a specified date and the passing of title from seller to buyer under conditions whereby: (1) buyer and seller are typically motivated; (2) both parties are well informed or well advised, and acting in what they consider their own best interests; (3) a reasonable time is allowed for exposure in the open market; (4) payment is made in terms of cash in U.S. dollars or in terms of financial arrangements comparable thereto; and (5) the price represents the normal consideration for the property sold, unaffected by special or creative financing or sales concessions granted by anyone associated with the sale.

Revised Appraisal Report, North Iowa Medical Center.[12]

The Provider also contends that the Purchase Agreement was negotiated at arm=s length between unrelated parties.[13] The Provider asserts that each party negotiated the sales transaction in furtherance of its own interests and objectives as evidenced by the comprehensive Purchase Agreement and related documents which memorialized the parties' rights and obligations with respect to the acquisition. The Provider and NIMHC were each represented by separate legal counsel, and the negotiations over the transaction were intense and lengthy.[14] As noted above, the Purchase Agreement contains numerous provisions which are typical of an asset purchase negotiated at arm=s length. For example, in addition to specifically defining the acquired assets and assumed liabilities, the Purchase Agreement contains substantial buyer's and seller's representations and warranties which are customarily included in such

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[12] Exhibit P-C.

[13] Provider Position Paper at 4. Tr. at 15 and 35-36.

[14] Tr. at 28.

sales transactions, as well as other typical provisions such as those concerning indemnification, the closing of the transaction and cooperation between the parties.

In addition, at the time the Purchase Agreement was negotiated and executed, there was no shared common control or ownership between the parties. No member of the Board of Trustees or the senior management of the Provider was a member of the Board of Trustees or senior management of NIMHC. Likewise, no member of the Board of Trustees or the senior management of NIMHC was a member of the Board of Trustees or senior management of the Provider.[15]
The Provider asserts that this conclusion, i.e., that there was no common control or ownership between the parties, is not altered by the fact that the Foundation was a subsidiary of the Provider and was the Class A member of NIMHC prior to June 11, 1993. The Provider explains that it is inappropriate to establish Arelatedness@ between the Provider and NIMHC on the basis of the relationship of the Foundation to the Provider and to NIMHC. The incorporation of NIMHC, including the creation of the membership rights of the Foundation and the purchase of the Provider by NIMHC is a single, integrated transaction, albeit occurring in two separate steps. The two steps had no significant separate purpose, and neither would have occurred but for the occurrence of the other. In significant respects, the transaction is similar to a two step transaction involving the purchase of stock in hospital A by hospital B followed by the consolidation of hospital A with and into hospital B. Under such circumstances, the two hospitals are not deemed related for purposes of the consolidation under Medicare reimbursement principles. See e.g., West Seattle General Hospital, Inc. v. United States 674 F.2d 899 (Ct. Cl. 1982). Likewise, the Provider and NIMHC should not be deemed related simply because one necessary step in the transaction preceded another.

Moreover, even assuming, arguendo, that it were appropriate to analyze the relationship of the Foundation to the Provider and to NIMHC prior to June 11, 1993 for purposes of determining relatedness, such analysis does not show that the Provider and NIMHC were related. First, the status of the Foundation as a subsidiary of the Provider and the Class A member of NIMHC clearly did not enable NIMHC to control the Provider or cause NIMHC and the Provider to be under common control. Second, the status of the Foundation with respect to the Provider and NIMHC simply did not confer upon the Provider control over NIMHC.

The Provider argues that in order for it to have had control over NIMHC through the Foundation, it would have had to possess the ability to significantly influence or direct the policies of NIMHC. However, the powers reserved to the Foundation in its capacity as the Class A member of NIMHC were very limited. Specifically, the only powers afforded the Foundation were an insignificant interest in

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[15] Tr. at 26.

the assets of NIMHC upon its dissolution and the right to approve actions of the Board of Directors or Class B member which would affect that interest. Significantly, the Foundation had no authority to approve, appoint, or remove any board member of NIMHC, or to approve, appoint, or remove the CEO or any other officer of NIMHC. The Foundation also had no authority to approve or initiate the amendment of NIMHC's governance documents or approve or initiate the amendment of the mission, philosophy, role or goals of NIMHC. Likewise, the Foundation had no authority to approve or affect the terms of the sales transaction. The Provider cites Biloxi Regional Medical Center v. Bowen, 835 F.2d 345 (D.C. Cir. 1987) (ABiloxi@), where the District of Columbia Circuit Court of Appeals concluded that a reversionary interest in certain assets of a hospital upon expiration of the 25 year lease between a city and the operator of the hospital did not confer control over the hospital upon the city holding that interest.

The Provider also argues that the Foundation=s interest in the residual assets of NIMHC upon its dissolution also does not confer control. Considering that the interest held by the Foundation would only become operative upon dissolution of NIMHC, it is clear that there was only a remote possibility that the interest would ever come to life.[16] In addition, just as in Biloxi, there are reasons for providing the Foundation with the residual interest in the assets of NIMHC, which are unrelated to a need or desire to control NIMHC. Specifically, the Foundation had existed to raise funds from the local community for the Provider. After the sales transaction, the Foundation would continue to exist and raise funds for NIMHC. In turn, NIMHC was controlled by SMHC, an entity headquartered outside the local community in which the Foundation and the Provider operated. Consequently, retaining an interest in the residual assets of NIMHC allowed the Foundation to prevent the resources it raised from leaving the community should NIMHC be dissolved.

The Provider contends that NIMHC also held no ownership interest in the Provider, and that the Provider held no direct ownership interest in NIMHC.[17] The Provider argues that even though the Foundation was a wholly-owned subsidiary and the Class A member of NIMHC, these relationships did not confer an ownership interest in NIMHC. As discussed above, it is not appropriate to establish Arelatedness@ between the Provider and NIMHC on the basis of the relationship of the Foundation to the Provider and to NIMHC. Also, even assuming such a basis were permissible, the relationships between the Foundation, the Provider and NIMHC would be insufficient to establish common ownership between the Provider and NIMHC.

The Provider adds that under Delaware law a member of a non-profit stock corporation is not an owner of that corporation. Factually, a non-profit corporation has no owners. Moreover, even if the

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[16] Tr. at 16.

[17] Provider Position Paper at 6.

Foundation's membership could be construed as an ownership by virtue of its residual interest in the assets of NIMHC, such ownership is not significant and does not justify a finding of relatedness. Under the formula by which the Foundation's interest would be calculated, only 18.81 percent of the residual assets of NIMHC would have conferred to the Foundation at the date of the sales transaction. The significance of this ownership interest can only be measured in the context of the level of concentration of the remaining ownership interest in NIMHC. Marina Mercy Hospital v. Harris, 633 F.2d 1301 (9th Cir. 1980). Notably, the only residual interest other than that of the Foundation was that of SMHC. Consequently, the Provider and NIMHC cannot be deemed related by shared common ownership at the time the Purchase Agreement was executed.

The Provider rejects the Intermediary=s reliance upon HCFA Pub. 15-1 ' 1011.1 which states:@ [i]f a provider and a supplying organization are not related before the execution of a contract, but common ownership or control is created at the time of execution by any means, the supply contract will be treated as having been made between related organizations.@Id.[18] While the Provider agrees that pursuant to this instruction common ownership or control may exist between otherwise unrelated parties as a result of rights created by a certain transaction, the Provider also contends that the Intermediary overstates the instruction=s applicability. In particular, the Provider argues that the Intermediary attempts to apply the principle embodied in HCFA Pub. 15-1 ' 1011.1 to the sales transaction involving the Provider and NIMHC through a misreading of HCFA Ruling 80-4 and HCFA Pub. 15-1 ' 1011.4.

The Provider explains that in the case giving rise to HCFA Ruling 80-4, Medical Center of Independence v. Harris, 628 F.2d 1113 (8th Cir. 1980) (AMedical Center of Independence@), a hospital appealed the denial of reimbursement claims for interest expense, management fees and rent on the basis that the costs associated with those expenses were set prior to any relationship between it and the supplier to whom payment for such costs were made. The Eighth Circuit Court of Appeals rejected this argument noting that A[w]hile the absence of any prior relationship between the parties is certainly relevant to the issue of control, it is insufficient to establish a per se rule barring application of the related party principle.@ Medical Center of Independence CCH & 30,654. The court was careful to point out, however, that the hospital and the supplier had entered into a long-term relationship during which "the terms of their agreement will be refined, modified and enforced in light of experience and the parties' respective power through the years.@Id. Significantly, the court distinguished the facts of its case from South Boston General Hospital v. Blue Cross of Virginia, 409 F. Supp. 1380 (W.D. Va. 1976)(ASouth Boston@), a case involving the one-time purchase of a facility.[19] In South Boston the court held that the related party rules did not apply at all to that purchase transaction.

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[18] Provider Position Paper at 7.

[19] Tr. at 17.

The Provider explains that the distinction noted by the court was also made by the Board in England Hospital, Inc. v. Arkansas Blue Cross and Blue Shield, Inc., PRRB Dec. No 78-D48, July 3, 1978, Medicare and Medicaid Guide (CCH) & 29,220 (AEngland Hospital@). Specifically, in England Hospital the provider argued that for purposes of determining whether it was related to the supplier of its facility and equipment and certain medical services, that its relationship should be analyzed only at the time of the negotiation and execution of the pertinent agreements because the terms of those agreements were fixed at that time. In rejecting this argument, the Board noted that the parties created a continuing relationship during which the extent to which services were utilized would be within the control of the supplier, and that the supplier would be in a position to control the amount of the rent under the lease. Significantly, the Board noted that if the issue were solely consideration of the sales price, the provider=s argument that the price was set during the negotiation and execution of the supply agreements, and prior to the creation of an ongoing relationship between the parties, would be relevant.

The Provider maintains, therefore, that based upon HCFA Ruling 80-4 and England Hospital, HCFA Pub. 15-1 ' 1011.1 stands for the proposition that otherwise unrelated parties can become related at the time of a transaction. However, it is equally clear that this program instruction does not apply to the instant case where there is a one-time transaction and no continuing relationship between the parties that can affect costs. At the time that the Purchase Agreement was executed, the Provider and NIMHC were not related. The fact that a minority of the Board of Trustees of the Provider were appointed to the Board of Trustees of NIMHC after June 11, 1993, is irrelevant. When those individuals were appointed they had no opportunity to affect the policies and actions of NIMHC with respect to the Purchase Agreement, including the purchase price, because the Purchase Agreement had been executed and the purchase price fixed.

The Provider contends that the Intermediary's reference to HCFA Pub. 15-1 ' 1011.4 is also misplaced.[20] The example cited by the Intermediary in that section of the manual involves the conversion of a hospital from a for profit corporation to a nonprofit corporation whose board of trustees are made up of former owners of the proprietary corporation. In the example, the buyer and seller are clearly related at the time of the transaction. Significantly, no reference is made in the example or anywhere else in HCFA Pub. 15-1 ' 1011.4 to the concept of continuity of control establishing Arelatedness@ in the context of a one-time sale of assets.

The Provider argues that even if the continuity of control principle were applicable to the instant case, the Provider and NIMHC were still not related parties.[21] Although 4 members of the 20 member

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[20] Provider Position Paper at Footnote 2.

[21] Provider Position Paper 9.

Board of Trustees of the Provider were eventually appointed by SMHC to serve as members of the 18 member Board of Trustees of NIMHC, those appointments occurred two weeks after execution of the Purchase Agreement and were completely voluntary on the part of SMHC. None of the terms of the sales transaction required that any member of the Board of Trustees of the Provider become a member of the Board of Trustees of NIMHC. Each of the members of the Board of Trustees of NIMHC are appointed solely by, serve at the pleasure of, and may be removed by SMHC, and SMHC was free to appoint, or not to appoint, individuals associated with the Provider. No member of the Board of Trustees of NIMHC was appointed or approved by the Provider.[22]

Further, none of the members of the Board of Trustees of the Provider, who became members of the Board of Trustees of NIMHC, had any ability to influence NIMHC with respect to the negotiation and execution of the Purchase Agreement. That is, they could not effect the agreement because it was negotiated and executed before they became members of the NIMHC=s Board of Trustees. And finally, the 4 members of the Board of Trustees of NIMHC associated with the Provider could not in any event significantly direct or influence NIMHC's policies and actions because, collectively, they represent only 22 percent of NIMHC=s board.

The Provider also rejects the Intermediary=s argument that the creation of NIMHC through the MOU established a related party situation.[23] The Provider explains that the MOU was non-binding and either side could cease negotiations at any time for any reason, including the Provider if it received a better offer. NIMHC remained dormant through the negotiation process and did not participate in, or influence the negotiations in any respect. Rather, NIMHC was created by SMHC to acquire the assets of the Provider and SJMH in the event a successful transaction was negotiated between the Provider and SJMH.

Finally, the Provider rejects the Intermediary's argument that restructuring the sales transaction to take advantage of favorable Medicare reimbursement treatment evidences a lack of arm=s length negotiations.[24] The Intermediary argues that the Provider converted the transaction that occurred in this case from a consolidation to a purchase in order to gain Medicare reimbursement through a loss on the disposal of its assets. However, this position completely ignores the fact that Medicare recognizes a loss from a merger or consolidation, as follows:[25]

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[22] Tr. at 17-18 and 29.

[23] Tr. at 35. Provider Post Hearing Brief at 5.

[24] Provider Post Hearing Brief at 7.

[25] See also Tr. at 18. Exhibit P-22.

> [a] consolidation is similar to a statutory merger, except that a new corporation is created. Medicare program policy permits a revaluation of assets affected by corporate consolidations between unrelated parties.
>
> EXAMPLE: Corporation A, the provider, and Corporation B (a non-provider) combine to form Corporation C, a new corporate provider entity. By law, Corporations A and B cease to exist. Corporations A and B were unrelated parties prior to the consolidation . . .
>
> The RO determines that the consolidation constitutes a CHOW [change in ownership] for Medicare certification purposes . . . A gain to the seller (Corporation A) and a revaluation of assets to the new provider (Corporation C) are computed.

Part A Intermediary Manual, Part 4 (AHCFA Pub. 13-4@) ' 4502.7. (Emphasis Added).

Therefore, Medicare reimbursement consequences are the same whether entities join through a consolidation or a purchase.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that its adjustment disallowing the Provider=s loss on the sale of its assets is proper. The transaction resulting in the transfer of the Provider=s assets was not a bona fide sale made at arm=s length. Rather, the transfer of the Provider=s assets was the result of a transaction between related parties pursuant to 42 C.F.R ' 413.17.[26]

The Intermediary cites HCFA Pub. 15-1 '' 1002.2 and 1002.3, which state: A[r]elated 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. Control exists where 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.@ Id.

Respectively, the Intermediary asserts that the Provider was related to the other pertinent parties in this

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[26] Intermediary Position Paper at 7. Tr. at 69.

case through its Foundation=s affiliation with NIMHC.[27] On November 19, 1992, the Provider, SJMH, and SMHC entered into a MOU which states in part:

> [t]he North Iowa Medical Center [ANIMC@] Foundation (the Foundation), currently a subsidiary corporation to NIMC will not be part of the consolidation and will be a member of MCH, with limited powers and with MCH as the recipient of funds raised by the foundation.

Memorandum of Understanding.

After the MOU had been entered into by the parties, a Purchase Agreement was executed on June 11, 1993, by and between NIMHC and the Provider. With this agreement all of the Provider=s assets were conveyed to NIMHC. As a requirement of the Purchase Agreement, a Transfer Agreement was also executed on this same date.[28] The Transfer Agreement was executed between NIMHC and SMHC. With this agreement, all of SMHC's rights to the assets of SJMH were conveyed to NIMHC. The Intermediary concludes that since the Provider was related to NIMHC that the Purchase Agreement at issue constitutes a related party transaction.[29]

In summary, the Intermediary asserts that from the date of the MOU the buyer and seller were related organizations. They were, in effect, participating as owners of a new entity that existed for the purpose of continuing the efficient utilization of the Provider=s facilities and those of SJMH. Also from this date, the parties were no longer behaving as buyers and sellers in the marketplace. A seller in such a transaction would generally offer its assets for sale in the marketplace seeking to get the highest price possible. A purchaser would be asking to purchase at the lowest price possible. However, the parties in this transaction did not behave like buyers and sellers in a bona fide sale. Instead, they were working to consolidate the operations of two facilities into a new corporation in which each hospital held an interest. Notably, there was no documentation available indicating that either party had searched the marketplace in order to determine the market value of the assets, or that the seller had advertised its desire to sell to the general market. Also notable is the fact that the appraisal made of the Provider=s assets to substantiate the fair market value was not available at the time the MOU was established or the Purchase Agreement executed.[30]

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[27] See Exhibit I-5.

[28] Exhibit I-3.

[29] Exhibit I-1.

[30] Intermediary=s Post Hearing Brief at 3. Tr. at 66-68.

The Intermediary also contends that the affiliation and control which exists between the Class A Member and NIMHC supports that a related organization situation exists between the Foundation and NIMHC. Moreover, the residuary interest that the Class A Member holds in NIMHC further supports that a related party transaction has occurred.[31]

Specifically, the Certificate of Incorporation of NIMHC (ACertificate@) explains that the business and affairs of NIMHC are managed by and under the direction of the Board of Directors. NIMHC has two classes of members. The Class A Member is the Foundation, which, as noted above, was a subsidiary corporation to the Provider. The Class A Member must approve actions by the Board of Directors or the Class B Member, SMHC, that would deny, limit, or otherwise prescribe the rights of the Class A Member. Item 9 of the Certificate states that upon dissolution of the corporation:

> [a] percentage of the net book value of the assets at the time of dissolution shall be distributed to the Class A Member; such percentage shall be equal to the NIMC Fund Balance divided by the Combined Fund Balance . . .

Certificate of Incorporation, North Iowa Mercy Health Center.

The Certificate goes on to state that these fund balances:

> shall be determined as of the date on which the Corporation acquires title to the assets of NIMC and SJMH.

Id.

The Intermediary contends that the composition of NIMHC=s Board of Directors also supports its position that the sales transaction at issue occurred between related parties. The Intermediary refers to a letter dated July 13, 1995 (Exhibit 1-6), in which NIMHC explains that 22 percent of the members of its board are from the Provider, 61 percent from SJMH, and 17 percent from new physician and community groups. The Intermediary asserts that this composition shows that the Provider had the ability to influence or control NIMHC.

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[31] Intermediary Position Paper at 8. Tr. at 70.

The Intermediary rejects the Provider=s argument that the Foundation is not related to NIMHC. The Intermediary refers to HCFA Pub. 15-1 ' 1002.1, which states: A[r]elated to the provider means that the provider to a significant extent is associated or affiliated with . . .@ Id. The Intermediary asserts, therefore, that a party does not have to be an owner to be considered related.[32] Accordingly, the fact that the Foundation is a member of NIMHC constitutes relatedness. Moreover, the purpose of the Foundation is to raise funds for NIMHC. This further establishes a related party association.

The Intermediary also rejects the Provider=s argument that the Foundation=s right to receive a distribution of 18.81 percent of the assets of NIMHC upon its dissolution is irrelevant, i.e., because its a Asmall@ percentage.[33] The Intermediary does not agree that a percentage of 18.81 is immaterial because it could result in a significant distribution of assets. This residuary interest that the Foundation holds in NIMHC as the Class A Member completely supports the fact that a related party transaction has occurred.

The Intermediary contends that the sales transaction at issue in this case is also deemed a related party transaction pursuant to HCFA Pub. 15-1 ' 1011.1.[34] In part, the manual states: [i]f a provider and a supplying organization are not related before the execution of a contract, but common ownership or control is created at the time of execution by any means, the supply contract will be treated as having been made between related organizations. HCFA Pub. 15-1 ' 1011.1. The Intermediary asserts that this rule holds true for agreements for the sale of assets during a change of ownership. And, with respect to the instant case, the hospitals were not related prior to the execution of the agreements which were entered into in June, 1993; however, these agreements resulted in a related party transaction.

The Intermediary asserts that the absence of a relationship between the Provider and the other pertinent entities prior to the merger does not preclude a finding of relatedness under Medicare=s related organization rules.[35] HCFA Ruling 80-4 holds, in part:

> [a]pplicability of the related organization rule which limits costs of a provider to those of its supplier is not necessarily determined by the absence of a relationship between the parties prior to their initial contracting, although this factor is to be considered. The applicability of the rule is determined by also considering the relationship between the

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32 Tr. at 72.

33 Intermediary Position Paper at 9.

34 Id.

35 Id.

parties according to the rights created by their contract.

HCFA Ruling 80-4.

The Intermediary maintains, therefore, that it is appropriate to analyze the relationship between a nonsurviving provider before a merger and a surviving provider after a merger. And, in this regard, considering that the board of directors of the surviving provider, NIMHC, include a substantial representation from the Provider, and because the Provider=s Foundation is the Class A member of NIMHC and holds the right to receive a percent of its assets in the event of dissolution, continuity of control exists.

Finally, the Intermediary explains that the concept of continuity of control is expressed in the regulations at 42 C.F.R ' 413.17 (b)(1) and (3) and in program instructions at HCFA Pub. 15-1 ' 1011.4. In particular, the Intermediary notes that the second example in the manual, while factually different from the situation at hand, illustrates continuity of control where substantially the same individuals controlled the nonsurviving provider both before and after a merger. The Intermediary asserts, therefore, that the related organization rules apply to the transaction at issue in this case. In fact, the decision to convert the transaction from a consolidation to a sale of assets was made at about the same time the composition of NIMHC=s board was announced to the Provider=s board.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

' 1395(x)(v)(1)(A)	-	Reasonable Cost

2. Regulations - 42 C.F.R.:

'' 405.1835-.1841	-	Board Jurisdiction
' 413.134 et seq.	-	Gains and Losses on Disposal of Depreciable Assets--General
' 413.17 et seq.	-	Cost to Related Organizations

3. Program Instructions-Provider Reimbursement Manual, Part I (HCFA-Pub.15-1):

' 1002 et seq.	-	Cost to Related Organizations-Definitions

' 1004.1 - Common Ownership Rule

' 1004.3 - Control Rule

' 1011.1 - Contracts Creating Relationship

' 1011.4 - Purchase of Facilities from Related Organizations

4. Program Instructions-Part A Intermediary Manual, Part 4 (HCFA Pub. 13-4):

' 4502.7 - Change of Ownership-Consolidation

5. Case Law:

Eastland Memorial Hospital v. Blue Cross and Blue Shield of Texas, PRRB Dec. No 96-D37, June 20, 1996, Medicare and Medicaid Guide (CCH) & 44,789, decl=d rev., HCFA Administrator, July 22, 1996.

West Seattle General Hospital, Inc. v. United States, 674 F.2d 899 (Ct. Cl. 1982).

Biloxi Regional Medical Center v. Bowen, 835 F.2d 345 (D.C. Cir. 1987).

Marina Mercy Hospital v. Harris, 633 F.2d 1301 (9th Cir. 1980).

Medical Center of Independence v. Harris, 628 F.2d 1113 (8th Cir. 1980).

South Boston General Hospital v. Blue Cross of Virginia, 409 F. Supp. 1380 (W.D. Va. 1976).

England Hospital, Inc. v. Arkansas Blue Cross and Blue Shield, Inc., PRRB Dec. No 78-D48, July 3, 1978, Medicare and Medicaid Guide (CCH) & 29,220.

6. Other:

Revised Appraisal Report, North Iowa Medical Center.

HCFA Ruling 80-4.

Memorandum of Understanding.

Certificate of Incorporation, North Iowa Mercy Health Center.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties= contentions, testimony elicited at the hearing, and post-hearing briefs, finds and concludes as follows:

The Provider sold essentially all of its assets to NIMHC. The Intermediary reviewed the transaction and determined that the Provider and NIMHC were related organizations. On that basis, the Intermediary effectuated an adjustment disallowing the Provider=s claim for a loss on the disposal of its assets.

The controlling authority regarding related party transactions is found at 42 C.F.R. ' 413.17. In part, the regulations state:

> [r]elated 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.
>
> 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.

42 C.F.R. ' 413.17(b)(1) and(3).

Based upon an analysis of the circumstances, events, and conditions relevant to the case, and contrary to the Intermediary=s determination, the Board concludes that the parties were not related prior to June 11, 1993, the date the Purchase Agreement was executed.

Initially, the Intermediary argues that its adjustment is substantiated by the affiliation established between the Provider and NIMHC through the MOU dated November 19, 1992. This argument is based upon the provision of the MOU explaining that the Foundation, a wholly owned subsidiary of the Provider, will not be part of the consolidation but will be a member of NIMHC. The Board, however, finds that

the MOU is not a legally binding document that establishes a significant affiliation between the parties. Rather, the MOU is a representation of the parties= intentions to continue negotiations as follows:

> [t]his Memorandum of Understanding does not constitute a binding agreement of the parties, but instead sets forth the present understandings and present intentions of the parties with respect to the consolidation. The parties intend to continue their mutual discussions and, in the event agreement is reached, reflect their mutual understandings in definitive agreements (the ADefinitive Agreements@) binding upon the parties, provided, however, until Definitive Agreements are reached and executed either party may terminate this Memorandum of Understanding at any time for any reason.

Memorandum of Understanding (emphasis added).[36]

Similarly, the Intermediary argues that its related party determination is supported by provisions of the Certificate of Incorporation (ACertificate@) of NIMHC that was filed with the Secretary of the State of Delaware on February 18, 1993. The Intermediary asserts that the Certificate further establishes an affiliation between the parties and confers the element of Acontrol@ over NIMHC to the Provider. These assertions are based upon the fact that the Certificate established the Foundation as the Class A Member of NIMHC with residuary rights to a minority interest in the assets of NIMHC should it ever be dissolved, and because the Certificate names four members of the Provider=s Board of Directors to NIMHC=s Board of Directors.

The Board again finds the Intermediary=s argument without merit. As noted, the Foundation=s right to a portion of NIMHC=s assets is a residuary right. The Foundation is not an owner of NIMHC or its assets. Moreover, at the time the Certificate was filed, NIMHC was essentially a shell with no operations or physical assets. As explained in the MOU, the Provider=s assets and those of SJHC would be conveyed to NIMHC only when, and if, the parties reached and executed Definitive Agreements, which has yet to occur. Likewise, naming individuals to a Board of Directors of a non-operating corporation also does not reflect an affiliation or an element of control as defined above. Notably, the Board finds that at this point the parties continue to be the Provider, SJHC and SMHC, that are continuing to negotiate within the guide of the MOU.The last event occurring prior to the actual sale of the Provider=s assets, which the Intermediary relies upon, is an April 5, 1993 meeting of the Provider=s Board of Directors. Here the Intermediary argues that the parties= affiliation is exemplified by the Provider=s discussion to change the proposed transaction from a consolidation with SJHC to an

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[36] Exhibit I-5

asset purchase in order to take advantage of Medicare=s reimbursement rules. Also at this time, the Provider is made unquestionably aware of the Foundation=s appointment as the Class A Member of NIMHC, and the appointment of certain of its directors to NIMHC=s Board of Directors.[37] The Board, however, finds no difference between this argument and the Intermediary=s argument regarding the incorporation of NIMHC discussed immediately above.

The Board notes, however, that the Intermediary rejects the subject transaction as being a bona fide sale due in part to the change in the structure of the transaction from a consolidation to an asset purchase, and because the value of the Provider=s assets was not confirmed until an appraisal report was issued on January 28, 1994. The Board, however, finds that the Intermediary did not develop this argument sufficiently to establish relatedness between the parties.
Finally, the Board rejects the Intermediary=s argument that the execution of the Purchase Agreement itself, on June 11, 1993, causes the sale of the Provider=s assets to become a transaction between related organizations.

Program instructions at HCFA Pub. 15-1 ' 1011.1, state in part:

> [i]f a provider and a supplying organization are not related before the execution of a contract, but common ownership or control is created at the time of execution by any means, the supply contract will be treated as having been made between related organizations.

HCFA Pub. 15-1 ' 1011.1.

Moreover, HCFA Ruling 80-4, states in part:

> [a]pplicability of the related organization rule which limits costs of a provider to those of its supplier is not necessarily determined by the absence of a relationship between the parties prior to their initial contracting, although this factor is to be considered. The applicability of the rule is determined by also considering the relationship between the parties according to the rights created by their contract.

HCFA Ruling 80-4.

Accordingly, the Board does not dispute the Intermediary=s position that absence of a relationship prior

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[37] See Copy of Board of Directors Minutes, Blue Cross and Blue Shield letter dated December 10, 1999, sent to Honigman Miller Schwartz & Cohn.

to a merger does not preclude a finding of relatedness for the purpose of applying Medicare=s related organization rules. The Board does find, however, that the Intermediary=s application of HCFA Pub. 15-1 ' 1011.1, in the instant case, is improper.

Essentially, the Intermediary argues that the Acontrol@ inherent to the Provider prior to June 11, 1993, continued to exist after the date of sale. The Intermediary bases this argument on the fact that four members of the Provider=s Board of Directors were appointed to NIMHC=s Board of Directors, and because the Provider=s Foundation was made the Class A Member of NIMHC holding residuary rights. Significantly, the Intermediary refers to the second example at HCFA Pub. 15-1 ' 1011.4, and maintains that the example, while factually different from the situation at hand, illustrates continuity of control where substantially the same individuals controlled the nonsurviving provider both before and after a merger.

The Board disagrees with the Intermediary=s position for several reasons. First, the Board does not believe the Foundation has the power to exert any influence upon the actions or policies of NIMHC. The Foundation exists primarily to raise funds from the community and, as explained in the Certificate of Incorporation, has very limited powers with respect to NIMHC. Also, the Board does not believe that four members of an eighteen member Board of Directors has the power to significantly influence or direct the actions or policies of a corporation. This is not to say that the four members of NIMHC=s Board of Directors selected from the Provider are without influence, but rather the degree to which that influence exists is less than is needed to Adirect@ the actions of the corporation. And finally, the Board finds that the element of control over NIMHC=s actions or policies after the merger has little or no relevancy to the case. Specifically, the appointment of the Provider=s members to NIMHC=s Board of Directors did not occur until June 24, 1993. Therefore, these individuals had no opportunity to effect the purchase price which had already been fixed, or the Purchase agreement which had already been executed.

DECISION AND ORDER:

The Purchase Agreement entered into and executed between the Provider and NIMHC was not a related party transaction. Therefore, the Provider=s claim for a loss on the disposal of its assets is proper. The Intermediary=s adjustment is reversed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr. Esq.
Charles R. Barker
Stanley J. Sokolove

FOR THE BOARD:

Irvin W. Kues
Chairman