# CENTERS FOR MEDICARE AND MEDICAID SERVICES

## *Decision of the Administrator*

| In the case of: | Claim for: |
|---|---|
| **UPMC-Braddock Hospital (Braddock Medical Center, Provider No. 39-0128)[1]** | **Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 11/30/96** |
| **Provider** | |
| **vs.** | |
| **Blue Cross /Blue Shield Association/ Veritus Medicare Services (n/k/a Highmark Medicare Services)** | **Review of: PRRB Dec. No. 2007-D54 Dated: July 31, 2007** |
| **Intermediary** | |

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

## BACKGROUND

For the cost year at issue, Braddock Medical Center (Provider) was a non-profit hospital located in Pennsylvania. The sole corporate member of the Provider was Heritage Health System (Heritage). Effective November 30, 1996, Heritage and its subsidiaries, the Provider (Braddock Medical Center) and Heritage Health Foundation (Foundation), entered into an Agreement to Merge and Affiliate

[1]Braddock Medical Center (Provider No. 39-0128) is the Provider. UPMC-Braddock, (the surviving entity following the merger) appealed the Notice of Program Reimbursement for the cost year at issue on behalf of Braddock Medical Center.

(Agreement) with the University of Pittsburgh Medical Center System (UPMCS). The Provider transferred its assets and liabilities to UPMCS pursuant to a merger of the Provider into a to-be-formed subsidiary of UPMCS to be named University of Pittsburgh Medical Center, Braddock (UPMC-Braddock). UPMC Braddock's sole corporate member was at all times UPMCS. The new surviving entity, UPMC-Braddock, assumed all the rights and obligations of the Provider under the Non-Profit Corporation Law of Pennsylvania and accepted assignment of the Provider's Medicare provider agreement. A terminating cost report was submitted for Braddock Medical Center for the period ending November 30, 1996, pursuant to which the Provider claimed a loss on the disposal of its assets resulting from the statutory merger. Upon audit of the cost report, the Intermediary disallowed the claimed loss on the basis that the merger was a transaction between related parties, pursuant to 42 C.F.R § 413.17 et seq. and the transaction was not a bona fide sale. The Provider appealed the Intermediary's disallowance to the Board.

## ISSUE AND BOARD'S DECISION

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

The Board held that the Provider is entitled to claim a loss on disposal of depreciable assets as a result of the statutory merger under the specific and plain meaning of 42 C.F.R. § 413.134(l)(2)(i), subject to: (1) the inclusion of $3,000,000 of consideration from the Foundation, and (2) review and audit of the Provider's "Booth method" allocation of consideration relating to the merger. The Board addressed the two fundamental arguments offered by the Intermediary in its denial of the Provider's claim. First, the Board stated that contrary to the Intermediary's arguments, the "Provider and BMC" were not related parties and, thus, the regulation at 42 C.F.R. §413.134(k)(2)(1) allows the assets of the merged corporations acquired by the surviving corporation to be revalued.

The Board found that the text at 42 C.F.R. §413.134(l)(2)(i) specifically states "if the statutory merger is between two or more corporations that are unrelated…" and is unambiguous in its meaning that the related party concept will be applied to the entities that are merging as they existed prior to the transaction. The Board found that the plain language of the regulation bars the application of the related party principle to the merging parties' relationship to the surviving entity. Furthermore, the Secretary's interpretive guidelines found at HCFA Pub. 13-4 § 4502.6, which stated in part: "Medicare program policy permits a revaluation of assets affected by

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

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

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

Finally, the Board found that the calculation of the loss should be based on the proportionate value method set forth in 42 C.F.R. § 413.134(f) (2) (iv). Pursuant to this methodology, the consideration at issue is allocated among all the assets acquired based upon the relationship of each individual asset's fair market value to the total fair market value of all the assets in the aggregate. The Board found that the "Booth pro-rata method," as revised by the Provider, needed to be reviewed and audited by the Intermediary. Therefore, the Board remanded the case to the Intermediary to perform the necessary audit procedures to ensure accuracy and appropriateness. The Board noted that in its review of the merger agreements that a significant amount of consideration was omitted from the loss on disposition calculation.[2] The Board found that the commitment of $3 million by the Heritage Heath Foundation was an inducement to UPMC-Braddock to enter into the merger transaction with the

[2] Specifically, Heritage Health Foundation was a party to the merger and affiliation agreement (See Provider's Exhibit P-2 at 001), and through a separate assignment agreement with the University of Pittsburgh Medical Center System, the Foundation committed $3 million to the Provider (See Provider's Exhibit P-2 at p.121).

Braddock Medical Center and, therefore, represents additional consideration that must be included in the computation of the loss.

## SUMMARY OF COMMENTS

### CMM Comments

CMM commented requesting that the Administrator reverse the Board's decision. CMM argued that the Board made several errors in its decision. First, the Board incorrectly found that, pursuant to 42 C.F.R § 413.134(l)(2), the Intermediary could only examine whether the parties to the merger were related prior to the merger transaction. Consequently, the Board rejected the Intermediary's argument that there was a continuity of control that resulted in the parties to the merger being related. CMM maintained that the Board's holding is erroneous and contrary to CMS policy which is longstanding and has been upheld by the courts.[3] CMM argued that it is well established Medicare policy that the related party rule also applies to relationships created through a merger transaction. CMM noted that in this case, there was a carry forward of board members pre and post affiliation that allowed the Provider's board of directors to significantly influence UPMC-Braddock. Thus, CMM contended that the Intermediary properly found that the merger was a related party transaction.

Second, CMM argued that the Board erred in finding that the merger was not subject to the bona fide sale requirement, of 42 C.F.R. §413.134(f)(2). The applicability of the bona fide sale rule to mergers is well established and has been upheld in court.[4] In the instant case, the transfer of assets from the merged provider corporation was not a bona fide, arms-length transaction between two non-related parties. There was never a bargaining or an attempt of maximizing fair market value of the purchase price being negotiated in an open market. CMM maintained that the transaction was not a bona fide sale, and that the Intermediary's disallowance should be upheld.

CMM further noted that the Board incorrectly interpreted the regulation at 42 C.F.R. §413.134(l) as requiring CMS to use the assumed debt of any corporation acquired through a merger as a basis for recalculating the provider's depreciation, regardless of the underlying facts. CMM alleged that the recalculation of depreciation is only appropriate when assets are sold for fair market value after arms length bargaining, and the facts of this case demonstrate that little or no consideration was paid for the

---

[3] See Albert Einstein Med. Ctr., Inc. v. Leavitt, 2007 U.S. Dist. LEXIS 55953.
[4] Id.

Provider's assets. UMPC-Braddock acquired all of the Provider's assets, including the value of its payment to the Provider, through the merger, and is not the sort of arms length transaction that can lead to a recalculation of depreciation.

**Provider Comments**

The Provider commented that the Board correctly determined that the Intermediary's disallowance of the loss claimed by the Provider was improper. The Provider cited a number of instances where the Intermediary failed to present evidence on almost all issues. The Provider argued that the Intermediary offered no evidence into the record on whether the transaction was a bona fide sale; whether there was any continuity of control between the pre and post merger entities; whether the Provider's loss calculations were inaccurate; whether a related party analysis under the regulation requires only a determination of whether there is a willing buy and seller who are well informed and acting in their best interests; and failed to explain how the 6 directors of the newly formed UPMC-Braddock, that had been members of either the Provider, Heritage or Foundation board of directors prior to the merger "controlled" the newly formed UPMC-Braddock in their minority position.

The Provider also argued that the Board's decision to require that $3,000,000 of additional consideration must be included in the computation of the loss should be modified as an erroneous interpretation of law unsupported by substantial evidence. The Provider argued that as a result of the Foundation having been a party to the Merger and Affiliation Agreement, and having committed, in its discretion, to hold separately $3,000,000 for support of those activities of UPMC-Braddock serving certain surrounding communities, the Board incorrectly found that this $3,000,000 represented additional consideration and must be included in the computation of the loss. Thus, the Provider argued that as the Foundation's authority to distribute the funds was completely discretionary and non-binding, the funds subject to this discretion should not be included in calculations of the consideration exchanged in the transaction.

## 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 CFR §413.9 states that all payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries.

### A. Capital Related Costs.

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

Title VI of the Social Security Amendments of 1983[5] 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[6] 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

[5] Pub. Law 98-21.

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

(as defined by the Secretary for periods before October 1, 1986)...." That provision was subsequently amended until finally, §4006(b) of OBRA 1987 revised §1886(g)(1) of the Act to require the Secretary to establish a prospective payment system for the capital-related costs of PPS hospitals for cost reporting periods beginning in fiscal year (FY) 1992.

**1. Depreciation.**

For cost years prior to the implementation of capital PPS, pursuant to the reasonable cost provision of §1861(v)(1)(A) of the Act, the Secretary promulgated regulations on the payment of capital costs, including depreciation. Generally, the payment of depreciation is based on the valuation of the depreciable assets used for rendering 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.[7]

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.

---

[7] 44 Fed. Reg. 3980 (Jan 19, 1979).

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

> (a) *General rule.* Capital related costs … are limited to:
>
> (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. [8]

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. [9] (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:

---

[8] 41 Fed. Reg. 35197 (August 20, 1976) "Principles of Reimbursement for Provider Costs: Depreciation: Allowance for the Depreciation Based on Asset Costs." (Proposed rule.)

[9] 44 Fed. Reg. 3980. (1979) "Principles of Reimbursement for Provider Costs."(Final rule.)

> (1) *General*. Depreciable assets may be disposed of through sale, scrapping, trade-in, exchange, demolition, abandonment, condemnation, fire, theft, or other casualty. If disposal of a depreciable asset results in a gain or loss, an adjustment is necessary in the provider's allowable cost. The amount of a gain included in the determination of allowable cost is limited to the amount of depreciation previously included in Medicare allowable costs. The amount of a loss to be included is limited to the un-depreciated basis of the asset permitted under the program. The treatment of the gain or loss depends upon the manner of disposition of the asset, as specified in paragraphs (f)(2) through (6) of this section ….(Emphasis added.)

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

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

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

> A bona fide sale contemplates an arm's length transaction between a willing and well informed buyer and seller, neither being under coercion, for reasonable consideration. An arm's length transaction is negotiated by unrelated parties, each acting in its own self interest. [10]

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

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

> by an independent appraisal expert to establish the fair market value of each asset and will make an allocation of the sale price in accordance with the appraisal.

Paragraph (f)(3) addresses gains or losses realized from sales within 1 year after the provider terminates from the program, while §413.134(f)(4) addresses exchange trade-in or donation[11] 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,[12] the new owner in the same transaction is interested in the determination of when Medicare will allow the revaluation of depreciation for purposes of calculating the new owner's depreciation expense.

This latter issue, on the revaluation of assets, was the subject of significant litigation for the Medicare program regarding complex transaction and resulted in agency rulemaking on the subject. In response to litigation, the regulations at 42 CFR §413.134(k)(1995).[13] 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:

---

[11] 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.

[12] 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.

[13] (1995) Originally codified at 42 CFR §405.415(l).

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

****

(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 merger is between two or more corporations that are unrelated (as specified in §413.17), the assets of the merged corporation(s) acquired by the surviving corporation may be revalued in accordance with paragraph (g) of this section. If the merged corporation was a provider before the merger, then it is subject to the provisions of paragraphs (d) (3) and (f) of this section concerning recovery of accelerated depreciation and the realization of gains and losses. The basis of the assets owned by the surviving corporation are unaffected by the transaction. An example of this type of transaction is one in which Corporation A, a nonprovider, and Corporation B, the provider, are combined by a statutory merger, with Corporation A being the surviving corporation. In such a case the assets of Corporation B acquired by Corporation A may be revalued in accordance with paragraph (g) of this section.
>
> (ii) Statutory *merger between related parties*. If the statutory merger is between two or more related corporations (as specified in §413.17), no revaluation of assets is permitted for those assets acquired by the surviving corporation. An example of this type of transaction is one in which Corporation A purchase the capital stock of Corporation B, the provider. Immediately after the acquisition, of the capital stock of Corporation B, there is a statutory merger of Corporation B and Corporation A, with Corporation A being the surviving corporation. Under these circumstances, at the time of the merger the transaction is one between related parties and is not a basis for revaluation of the provider's assets.

**B. Related Organizations**

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

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

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

> This rule applies whether the provider organization or supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or nonprofit. In the case of nonprofit organization, ownership or equity interest will be determined by reference to the interest in the assets of the organization (e.g., a reversionary interest provided for in the articles of incorporation of a nonprofit corporation).[14]

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:

---

[14] 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, (CCH) Para. 30,656 (8th Cir. 1980).[15] The Ruling pointed out that the applicability of the related organization rule is not necessarily determined by the absence of a relationship between the parties prior to their initial contracting, although those factors are to be considered. The applicability of the rule is determined by also considering the relationship between the parties according to the rights created by their contract. The terms of the contracts and events, which occurred subsequent to the execution of the contract, in that case had the effect of placing the provider under the control of the supplier.

**C. Interaction of the Various Regulations.**

The Administrator also notes the interaction of the various regulations with 42 C.F.R. §413.134(1).[16] The Administrator finds that, as the issue under appeal involves the

---

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

[16] While not dispositive to this case, the CMS policy on consolidation revaluations in the final rule published on February 5, 1979 was not a change from the proposed rule published in April 1, 1977. The final rule states that it does not differ in substance from the proposed rule (44 Fed. Reg. 6913) and it was made effective on the date

recognition of depreciation losses on the transfers of assets from a merger between non-profit entities, he cannot limit his review to the specific merger requirements of 42 C.F.R. §412.134(1). Paragraph (1) was initially drafted to address the revaluation of assets for proprietary corporations, while paragraph (f) specifically addresses circumstances under which a gain or loss will be recognized. Paragraph (1) did not modify or limit the general related party rules at §413.17 and does not address or modify the criteria for the payment of gains or losses at paragraph §413.134(f). Instead, the Secretary explicitly stated that this provision was being promulgated consistent with both the related party rules and the disposal of depreciable asset rules set forth at paragraph (f).[17]

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

---

published, an act consistent with that statement. An immediate effective date for any substantive change would have required a good cause exception under the Administrative Procedure Act (APA) published in the final rule. The final rule also stresses that the policy that the rule clarifies on the revaluation of assets is longstanding policy Medicare policy and does not note any changes on consolidations as a result of comments. The change referenced from the proposed rule is that the final rule dedicates separate paragraphs to related and unrelated transactions involving consolidations, similar to that provided for statutory mergers. Thus, based on the foregoing, one could conclude that this change was to clarify the proposed language, rather than to promulgate a substantive change from the proposed rule.

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

**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 recognized that, inter alia, certain relationships formed as a result of the merger or consolidation of two entities constituted a related party transaction for which a loss on the disposal of assets could not be recognized. The PM stressed that "between two or more corporations that are unrelated" should include the relationship between the constituent hospitals and the consolidating entity. Consequently, the PM A-00-76 states that:

> whether the constituent corporations in a merger or consolidation are or are not related is irrelevant; rather the focus of the inquiry is whether significant ownership or control exists between a corporation that transfers assets and the corporation that receives them.

The PM stated that the term "significant", as used in the PM has the same meaning as the term "significant" or "significantly", in the regulations at 42 C.F.R. § 413.17 and the PRM at Chapter 10. Important considerations in this regard include that the determination of common control is subjective; each situation stands on its own

merits and unique facts; a finding of common control does not require 50 percent or more representation; there is no need to look behind the numbers to see if control is actually being exercised, rather the mere potential to control is sufficient.

In addition, the PM stated that many non-profit mergers and consolidations have only the interests of the community at large to drive the transaction. This community interest does not always involve engaging in a bona fide sale or seeking fair market value of assets given. Rather, the assets and liabilities are simply combined on the merger/consolidated entities books. The merged/consolidated entity may or may not record a gain or loss resulting from such a transaction for financial reporting purposes. However, notwithstanding the treatment of the transaction for financial accounting purposes, no gain or loss may be recognized for Medicare payment purposes unless the transfer of the assets resulted from a bona fide sale as required by the regulation at 42 C.F.R § 413.134(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.

Notably, the Administrator finds that the requirement that the term "between related organizations" includes an examination of the relationship before and after a transaction of assets under 42 C.F.R. § 413.417 (§ 405.17), was applied as early as 1977 by the agency in evaluating whether accelerated depreciation would be recaptured. The agency decided that "when the termination of the provider agreement results from a transaction between related organizations and the successor provider remains in the health insurance program and its asset bases are the same as those of the terminated providers, health insurances reimbursement is equitable to all parties." [18] Thus, the depreciation recovery provisions would not be applied. 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.[19] Thus, the PM interpretation of the related party rules as requiring an examination of the relationship before and after the transfer of assets is consistent with early Medicare policy and HCFAR 80-4.

---

[18] 42 Fed. Reg. 45897 (1977).

[19] 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.)

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

> Corporation A and Corporation B, both non-profit providers, are combined by statutory merger with Corporation A surviving. Corporations A and B were unrelated prior to the transaction, each being controlled by its respective Board of ten Directors. After the merger, Corporation A's new ten member Board of Directors includes five individuals that served on Corporation B's pre-merger board. Thus, Corporation A's new Board of Directors includes a significant number of individual from both of the former entities' boards. Because no significant change of control of the assets of former Corporation B has occurred, the transaction as between Corporation A and Corporation B is deemed to be between related parties and no gain or loss will be recognized as a result of the transaction. Hence, Medicare reasonably examines the relationship between the merging corporations and the surviving corporation and recipient of the Medicare depreciable assets to determine whether the transfer involved a related party transaction.[20]

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

The Intermediary Manual, Chapter 4000, et seq., also addresses changes of ownership (CHOW) for purposes of Medicare certification and reimbursement. These sections provide guidelines based on Medicare law, regulations and implementing instructions for use by the Medicare intermediaries and providers on the reimbursement implications of various types of changes of provider organizations transactions or CHOWs. Section 4502 explains that the first review of a CHOW transaction is to determine the provider structure both before and after the transaction and to determine the type of transaction which occurred because Medicare has developed specific policies on the reimbursement effect of various types of CHOW transactions which may be different from treatment under generally accepted accounting principles or GAAP. Section 4502.1, list the various types of provider 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

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

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,[21] in addressing stock corporations states that, Medicare program policy places reliance on GAAP, as expressed in APB No. 16 in the reevaluation of assets and gain/loss computation processes for Medicare reimbursement purposes. While in certain areas, Medicare program policy deviates from that set forth in GAAP,[22] 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.

---

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

[22] 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).

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

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

This policy of not recognizing a gain or loss when the transaction is between related parties, whether it constitutes a reorganization, consolidation or merger, is also consistent with Internal Revenue Service (IRS) rules on the non-recognition of a gain or loss when a statutory reorganization has been determined to have occurred. Relevant to this case, while the Medicare rules may diverge from IRS rules and Medicare policy is not bound by IRS policy, IRS policy often reflects rationale underlying the establishment of similar policies under Medicare.[23] In fact, in setting forth principles applicable to the recognition of the gain or a loss, CMS has in the past recognized the similarity of the Medicare principles and the IRS principles and has often explicitly stated when such Medicare policy agrees or diverges from IRS treatment.[24]

---

[23] 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).

[24] 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 IRS (IRS), the un-depreciated value of the traded asset, plus any additional assets transferred to acquire the new assets, are used as the basis for depreciation of the new asset under Medicare"; 48 Fed. Reg. 37408 (Aug. 18. 1983) (finding that it was not appropriate for the Medicare program to use IRS

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.[25] For example, a merger where the predecessor corporation board continues significant control in the new corporation board is treated the same as reorganization for Medicare reimbursement purposes and no gain or loss is recognized. However, for example, where the predecessor corporation board does not continue significant control in the new corporation board, a gain or loss will be recognized for Medicare reimbursement purposes.

Similar to Medicare rules, the IRS does not allow the recognition of the gain or loss when there is a re-organization, inter alia, because no gain or loss has in fact been realized. As the courts have noted:

> The principle under which statutory reorganizations are not considered taxable events is that no substantial change has been affected either in the nature or the substance of the taxpayer's capital position, and no capital gain or loss has actually been realized. Such a reorganization contemplates a continuity of business enterprise and a continuity of interest and control accomplished [in this instance] by an exchange of stock for stock.[26] (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

---

accelerated costs recovery system for Medicare purposes and deleting IRS useful life guidelines).

[25] 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.")

[26] 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).

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."[27] 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."[28]

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

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

Consequently, one purpose of the IRS policy 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

---

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

[28] 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)).

cost has been incurred under the foregoing facts, Medicare similarly does not find that the provider has incurred an actual cost for purposes of Medicare reimbursement under such facts.

## II. Finding of Facts and Conclusion of Law.

This particular case involves the Provider's claim for a loss on the disposal of assets as a result of a merger. The transaction involved UPMCS[29] and the Provider, Braddock Medical Center. Prior to the merger, the Provider was a non-profit corporation operating in Pittsburgh, Pennsylvania and a duly licensed acute general hospital under Pennsylvania law.[30] Heritage Health System was the Provider's sole corporate member. The Provider's governance and control pre-merger was vested solely in its board of directors and in its sole corporate member, respectively. Heritage Health Foundation was a subsidiary of Heritage Health System and, hence, related to the Provider prior to the merger date. Both before the merger and, thereafter, the Foundation's charitable purpose was to provider support of a charitable nature for the medical needs of the Provider community through fundraising.[31]

On October 28, 1996, Heritage Health System, the Provider, and the Foundation entered into an Agreement to Merge and Affiliate with UPMCS. The Provider agreed to transfer all its assets and liabilities to UPMCS pursuant to a merger of the Provider into a to-be-formed subsidiary of UPMCS, UPMC-Braddock. UPMC-Braddock was incorporated October 1996.[32] Following the merger, UPMC-Braddock assumed all rights and obligations of the Provider. [33] However, UPMC-Braddock (which did not constitute a pre-existing hospital prior to the merger) accepted Medicare assignment of the Provider's (Braddock Medical Center) provider agreement and hence its provider number.[34] The assets, liabilities, reserves and accounts of the Provider were taken up on the books of UPMC-Braddock at the amounts they were being carried on the books of the Provider immediately prior to the closing, subject to any adjustments which were required in accordance with generally accepted accounting principles giving effect to the merger date.

---

[29] UPMC was also the parent corporation of three other hospitals. See Provider Exhibit P-40.

[30] See Provider Exhibit P-16, ¶4.

[31] See Provider Exhibit P-16, ¶4.

[32] See Provider Exhibi P-5.

[33] See Provider Exhibit P-16, ¶31 and 37.

[34] See Provider Exhibit P-41. Hence, while the corporate existence of Braddock Medical Center may have ceased after the merger, it is not totally accurate to state that the "Provider" as identified as Provider No. 39-0128, ceased to exist after the merger for Medicare reimbursement purposes.

After the merger, the Agreement provided for a new structure of the governing board. Specifically, two-thirds (2/3) of the votes held by directors of the board of UPMC-Braddock were to be appointed by UPMCS, and not less than one-third (1/3) or six of the votes held by directors of UPMC-Braddock was to be appointed by Foundation (controlled by Provider's parent).[35] The Agreement also called for Thomas Sterling, the chairman of the Provider (Braddock Medical Center), to carry over and become the chairman of UPMC-Braddock, through December 31, 1997.[36] The Agreement required that the directors of Foundation be consulted about certain future fundamental changes of UPMC-Braddock which may be recommended by the UPMC-Braddock Board or UPMCS. The directors of the Foundation were also given the right to appoint either one director to the parent corporation UPMCS' governing body, or one member to any applicable community advisory committee which may be established by UPMCS.[37]

Applying the statute, regulations, PRM, and Medicare policy to the facts of this case, the Administrator finds that based on a combination of factors the parties to the merger are related through control. As a preliminary matter, the Administrator finds that the Provider in this case claiming the loss on the disposal of assets is Braddock Medical Center (also referred to as BMC) and not UPMC-Braddock, the surviving entity.[38] In addition, the record shows that Heritage Health Services was the sole member of Braddock Medical Center and Heritage Foundation prior to the merger. Thus, Heritage Foundation was related to Braddock Medical Center at the time of the transaction.

In applying the related party principles at 42 C.F.R. § 413.17, the Administrator finds that consideration must be given as to whether the composition of the new board of directors of the surviving corporation included significant representation by the Provider (Braddock Medical Center, i.e., BMC); its parent corporation Heritage Health Services; or its subsidiary Heritage Foundation,[39] and in that way shows a continuity of control over the surviving entity UPMC-Braddock. If such is the case, then no real change of control of assets has occurred and no gain or loss will be

---

[35] Provider Exhibit P-2, Agreement to Merge and Affiliate, Paragraph 7(a)(i), p.8.
[36] Provider Exhibit P-2, Agreement to Merge and Affiliate, Paragraph 7(a)(i), p.9.
[37] Provider Exhibit P-2, Agreement to Merge and Affiliate, Paragraph 7(a)(iv), p.10
[38] See January 25, 2000 letter from UPMC-Braddock on behalf of Braddock Medical Center Requesting a Board Hearing, enclosing "Notice of Program Reimbursement, For the Cost Reporting Period From July 1, 1996 Through November 30, 1996 For Braddock Medical Center (Provider No. 39-0128)," dated August 3, 1999.
[39] Heritage Health System (parent corporation) and Heritage Foundation continued to exist after the merger. Provider Exhibit P-44.

recognized as a result of this transaction. As stated above, the term "control" includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised.

The Administrator finds in this case, that the new governing board of the surviving entity was to consist of a total of 18 members, sic votes were to represent the Foundation and 12 votes were to represent the parent corporation, UPMCS. In addition, Heritage Foundation was allowed representation on the new parent UPMCS' board of directors. Thus, the record shows that the Foundation board members were to represent at least 33.3 percent of the voting positions in the surviving entity's board of directors.[40] The record also shows that the former Chairman of the Provider, Thomas Sterling, carried over to become the Chairman of UPMC-Braddock. Thus, the merged entity's new board of directors included significant representation for the Provider that showed a continuity of control.

In addition, the record shows that all of the Provider's existing management staff was retained to manage UPMC-Braddock, along with the medical staff.[41] The record shows that the UPMC-Braddock continued with the same mission as the Provider, and that the new parent organization UPMCS committed to invest in the Provider's post-merger facilities as a condition of the merger to enable the continuation of this mission.[42]

The Administrator finds that this carry-forward of the representation of Provider (Foundation), post-merger, on the board and the continuation of the Provider's management team enabled the Provider to maintain influence and continuity of control in the surviving merged entity. While the Administrator recognizes that the percentage of the Provider's representation on the board of directors was not a

---

[40] Provider Exhibit P-2, Paragraph 7(a)(i), p.8.

[41] See, e.g., Provider Exhibit P-20; Provider Exhibit P-40 ("The existing management staff of [Braddock] has been retained to manage [UPMC-Braddock]. The current medical staff of [Braddock] will continue as the medical staff of [UPMC-Braddock]."") Contracts for the Provider's executive management staff were assigned to UPMC- Braddock. Moreover, all employees were transferred to the payroll of UPMC-Braddock. Provider Exhibit P-22.

[42] Provider Exhibit P-19. UPMC Letter dated November 28, 1996, memorializing a capital improvement plan of $10 million by UPMC and commitment for tangible capital improvements at Braddock Medical Center. See also Provider Exhibit P-2 Agreement to Merge and Affiliate, Paragraph 7(g) which provides that UPMC, UPMC Braddock and the Foundation will jointly prepare and submit to their respective boards for approval a development plan intended to reasonably assure an economically viable health care delivery site in Braddock.

majority, the size of the Provider's representation post-merger, reflected its reorganization into a larger entity. Because no significant change of control of the assets of the Provider has occurred, the Administrator finds that the merger of the Provider into UPMC-Braddock is between related parties and no gain or loss will be recognized as a result of the transaction. Thus, based on the totality of the circumstances, the Administrator finds that the Provider is related through continuity of control with the surviving corporation and not entitled to a loss on the disposal of assets.

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

In addition, the Administrator finds that the transaction was not consummated through an arm's length transaction. A bona fide sale contemplates an arm's length transaction, between unrelated parties for reasonable consideration, with each party acting in its own self interest. As outlined in PM A-00-76, in evaluating whether a bona fide sale has occurred with respect to a merger or consolidation between or among nonprofit entities, a comparison of the sale price with the fair market value of the assets acquired is required. A large disparity between the sale price (consideration) and the fair market value of the assets sold or transferred indicates the lack of reasonable consideration and, hence, the lack of a bona fide sale. Examples of transactions that raise the issue of a bona fide sale are set forth in PM A-00-76:

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

The PM A-00-76 further states that:

> Non-monetary consideration, such as a seller's concession from a buyer that the buyer must continue to provide care for a period of time or to

> provide care to the indigent, may not be taken into account in evaluating the reasonableness of he overall consideration (even where such elements may be quantified in dollar terms). These factors are more akin to goodwill than to considerations.

In this case, the record shows that assets were transferred from the Provider to the surviving entity for the assumption of liabilities totaling approximately $13 million.[43] The net book value of all the assets was listed as approximately $26,416,394.[44]

Of that amount, the current assets were listed as having a value of approximately $15,726,037 (and funded depreciation of $200,000). When certain deductions for bad debts, etc, are recognized, the current/cash assets are reduced from approximately $15 million to just under approximately $10,000,000 in current/cash assets.[45] The Provider's land, non-monetary and depreciable assets were listed as having an approximate net book value of $10,490,337. Using the cost approach, the fair market value of the land and depreciable assets was appraised at approximately $13,325,000.[46] The Administrator finds that comparing the Provider's liabilities and the value of the Provider's transferred current/cash assets alone shows that the non-monetary assets (e.g., land, buildings, etc.) were transferred for approximately $3 million or approximately 1/3 of the net book value and less than 1/4 of the fair market value. This amount of consideration transferred (assumption of the debt) and the value of the assets received does not, in the Administrator's view, support a finding that the Provider transferred assets for reasonable consideration and as a result of a bona fide sale.

However, as the Board noted, the record also shows that the Heritage Foundation was to make distributions of $3 million dollars to benefit the surviving entity.[47] That is, as an incentive for UPMCS to merge with the Provider (Braddock Medical), an additional $3 million was to be distributed from the Foundation (the former charity-raising arm of Braddock Medical) for the benefit of the surviving corporation UPMC-Braddock. Contrary to the Board's finding, this does not appear to be consideration transferred by the "purchaser" UPMCS to acquire the assets, but rather

---

[43] Intermediary's Exhibit I-8.

[44] Intermediary's Exhibit I-8.

[45] See also Intermediary Exhibit I-11, showing current and cash assets of $9,700,491, which appears to reflect the deduction of $5.1 million for bad debts and $913,000 for 3rd party contracts from the $15 million.

[46] Id.

[47] Provider Exhibit P-21.

was an additional cash asset to be distributed from the Provider's Foundation[48] to the "buyer" as part of the merger. The additional $3 million of assets to be distributed to benefit UPMC-Braddock (in addition to the $10 million in current/cash assets) brings the total of current and cash assets transferred to and otherwise benefiting the surviving entity to an amount equivalent to the Provider's liabilities of approximately $13 million, resulting in the transfer of the depreciable assets for no consideration.[49] When assets are transferred for no consideration, a donation has occurred and no loss may be calculated under those terms. Thus, the examination of the transaction in its totality further emphasizes that no bona fide sale occurred as a result of the merger in this case.

In addition, the record further shows that at the time of the merger no appraisal of the Provider's assets had been conducted to determine the fair market value. The record shows that the appraisal of the Provider's land and realty assets was conducted after the merger on April 16, 1997. The fact that the parties did not secure an appraisal prior to the transaction is also an indication that the Provider was not concerned with receiving reasonable consideration for its depreciable assets. The record does not show that receiving the best possible price for the facilities was a major factor in the negotiations.

Instead, the Administrator finds that other non-monetary factors appear to form the basis for the merger including the determination that a merger would enable the parties to better achieve their respective charitable purposes, allow the Provider to develop enhanced clinical capabilities with the proposed parent corporation UPMC, permit the Provider a more efficient and cost effective rationalizing of healthcare services, restrain the costs of services and increase managed care opportunities.[50] Further, the parties to the merger determined that a merger would be in the best interest of the respective nonprofit corporations as well as the communities they served and would advance their respective corporate missions.[51] These factors were a primary motivation behind the merger and the record does not show any discussion for determining that the assumption of debt was fair consideration for the Provider's assets. Thus, the Administrator finds that, as the transaction did not involve an arm's length transaction, the transaction was not a bona fide sale as required under the regulations and PRM for the recognition of a loss on the disposal of assets.

---

[48] The Provider's Foundation was to receive the reimbursement for loss on disposal of assets reimbursement.

[49] The record shows that at the actual time of the merger some of the numbers had changed but not significantly.

[50] Affidavit of Thomas Boyle, p.6.

[51] Id.

As a loss cannot be allowed in this case, the Administrator does not reach the issue of the method to be used to calculate the loss on disposal of depreciable assets. However, the issue of calculating a loss does point out certain anomalous results of finding that a loss is to be calculated in a case when there has been no bona fide sale. If the liabilities are treated as "consideration" and are first allocated on a dollar to dollar basis to the total transferred current/cash assets (including the recognition of the $3 million), the Provider, in essence, transferred the depreciable assets for no consideration. Such a transaction is consistent with the definition of a donation and no loss may be recognized under Medicare policy when there is a donation of the asset. Otherwise, for consideration to be allocated to the depreciable assets (again, recognizing the $3 million as part of the transferred current/cash assets), a less than dollar to dollar pro-ration of the sale price must be made to the current/cash assets. The Administrator concludes that, both methods highlight the fact that no bona sale occurred and, thus, no loss can be calculated under the facts of this case.

Consequently, the Administrator finds that, not only was the transaction between related parties, but that there was no bona fide sale or other event which is required under 42 C.F.R. §413.134(f) for a loss to be recognized in this case.

## DECISION

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

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

Date: 9/27/07

/s/
Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services