CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Allentown Osteopathic Medical Center	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 12/31/96**
Provider	
vs.	
Blue Cross Blue Shield Association/ Vertius Medicare Services (n/k/a Highmark Medicare Services)	**Review of: PRRB Dec. No. 2008-D15 Dated: January 24, 2008**
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)). Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. The Center for Medicare Management (CMM) submitted comments, requesting reversal of the Board's decision. The Provider also submitted comments, requesting that the Administrator affirm. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

On October 16, 1996, a Merger Agreement (Agreement) was entered into between the Provider and St. Luke's Hospital (St. Luke's).[1] Under the terms of the agreement, effective January 1, 1997, the Provider was merged into St. Luke's with the latter as the surviving entity. St. Luke's also agreed to maintain and operate an acute inpatient services hospital at the Provider's campus for a minimum of two years after the merger, unless an operating loss of $75,000 or more per month for six months, or a cumulative loss of $500,000 for any rolling six-month period was incurred.[2] After the two-year period, inpatient services would continue, unless a

[1] Provider's Exhibit P-1.
[2] Id., p. 3 § 2.4 et seq.

cumulative operating surplus, on the six-month rolling basis, was not maintained. In addition, St. Luke's agreed to invest in the Provider's campus plant, equipment, programs and services. St. Luke's would also continue to recognize osteopathic medical philosophy, training programs and accreditations.[3] The Provider's Board of Trustees would also serve as an "other body" under Pennsylvania Law, in an advisory capacity.[4]

As a result of the transaction, the assets and liabilities of the Provider were transferred to St. Luke's Hospital.[5] The consideration incurred by St. Luke's was determined to be the assumption of debt in the amount of $4,848,188.[6] Upon audit of the Provider's cost report for fiscal year ending December 31, 1996, the Intermediary disallowed the loss claimed by the Provider.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's adjustment, disallowing the loss claimed by Provider, was proper.[7]

The Board held that the Provider was entitled to claim a loss on disposal of depreciable assets as a result of the statutory merger of the Provider and St. Luke's under 42 C.F.R. § 413.134(l)(2)(i). The Board determined that, since there was a

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[3] Id., p.4 § 2.8.

[4] Id., p. 2 § 2.1 et seq; Transcript of Oral Hearing (Tr). at 186-88.

[5] Provider's Exhibit P-1, P-17.

[6] Provider's Exhibit P-93.

Allocated Consideration Liabilities

Current Portion of Long Term Debt	$ 656,925
Accounts Payable	$ 439,519
Estimated Third Party Settlements	$ 858,168
Advances from Third Party Payors	$ 481,800
Due to St. Luke's-Bethlehem/Q'twn	$ -
Accrued Payroll, Vacation, Taxes	$1,214,372
Accrued Other	$ 193,893
Long Term Debt-Leases/Note Payable	$ 942,511
Accrued Malpractice Costs	$ 91,000
	$ 4,848,188*

* Excludes $177,984 Current Liabilities amount for "Due to St. Luke's-Bethlehem/Quakertown."

[7] Section 4404 of the Balanced Budget Act of 1997 (Pub. L. 105-33) amended §1861(v)(1)(O)(i) of the Social Security Act to terminate Medicare recognition of gains and losses for depreciable assets resulting from either their sale or scrapping. Conforming modifications to the applicable regulation were made December 1, 1997, the effective date for implementing the new rule.

specific regulation that controlled the recognition of a loss on mergers, the merger in question was not required to meet the *bona fide* sales transaction addressed in 42 C.F.R. § 413.134(f)(2). The Board found persuasive that, in light of the changing healthcare environment and lack of a market for the Provider's facilities, the assumption of liabilities assumed in the merger equated to the fair market value of the Provider's assets.

With respect to the allocation of the consideration, the Board found that the "Booth pro-rata method," as revised by the Provider, needed to be reviewed and audited by the Intermediary. Accordingly, the Board remanded the case to the Intermediary to perform the necessary audit procedures to ensure accuracy and appropriateness of the loss calculation and to review the documentation related to the $177,984 liability due to St Luke's-Bethlehem/Quakerstown that was excluded from the consideration. The Board found the Provider's explanation insufficient to determine if the liabilities addressed should have been considered part of the consideration used in the loss calculation.

Finally, the Board disagreed with the Provider's argument that the Deficit Reduction Act (DEFRA) adjustment did not apply to the year at issue. Relying on *Bethesda Hospital Ass'n, v Bowen*, 485 U.S. 399 (1988), which held that the Board may go beyond issues directly before it if the Board deems it necessary, the Board held that DEFRA adjustment must be applied to prevent the Medicare program from paying excess depreciation cost. The Board determined that this adjustment was necessary because the merger transaction was treated as a pooling of interests for accounting purposes, and the value of the assets transferred to St. Luke's in the merger were not "written down." As a result, St Luke's continued to claim depreciation for these assets at their carrying value on the Provider's books at the date of the transaction without considering the decline in their value as evidenced by the loss.[8]

[8] The Provider disagreed with the Board's determination that the amount of the allowable loss should be reduced by the depreciation expense that would have been claimed on the merged assets by the surviving corporation. The Administrator notes that Allentown Osteopathic Medical Center is the Provider before the Board on this appeal, and its cost reporting period is FYE 12/31/1996. Accordingly, the Administrator finds that the subsequent years of the surviving entity (St. Luke's) are not before the Board in this case.

SUMMARY OF COMMENTS

CMM submitted comments requesting that the Administrator reverse the Board's decision. CMM disagreed with the Board's determination that the merger was not subject to the *bona fide sale* requirement of 42 C.F.R. § 413.134(f)(2).

CMM argued that the Provider failed to show that there was a *bona fide* sale of its depreciable assets. CMM argued that the transaction was not a *bona fide* sale due to the great discrepancy between the value of the assets and the consideration properly allocated to them. The Provider transferred total assets valued at approximately $25,171,498 in exchange for approximately $4,848,188, in assumed liabilities. The Provider only received 20 percent of the value of its assets. The record showed that the Provider had discussions with five potential affiliation partners. However, the Provider accepted inadequate compensation for its assets and, therefore, the transaction was not a *bona fide* sale.

The Provider submitted comments requesting that the Administrator affirm the Board's decision to allow the loss on sale. However, the Provider disagreed with the Board's decision to remand the case to the Intermediary for further determination as to the appropriateness of including the $177,984 liability due to St Luke's-Bethlehem/Quakertown in the consideration amount. The Provider argued that the Intermediary had already performed an audit of this transaction on three separate occasions and determined that the liability should not be included in the consideration amount.[9] Accordingly, no further audit work was necessary regarding this issue.

The Provider also submitted comments disagreeing with the Board's decision to remand the case to the Intermediary for a determination of the Medicare utilization rate used to determine Medicare's share of the loss. The Provider argued that the Intermediary had already audited this issue and no further work was necessary. The Provider noted that the Medicare utilization rate determined by the Intermediary was larger than the one used by the Provider to determine Medicare's share of the loss. However, if the Administrator and or Board would prefer to use the Medicare utilization percentage computed by the Intermediary the Provider had no objection.

DISCUSSION

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

[9] Provider's Comments, n.2.

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 therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The Act further authorizes the Secretary to promulgate regulations establishing the methods to be used and the items to be included in determining such costs. Consistent with the statute, the regulation at 42 C.F.R. § 413.9 states that all payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries.

A. Capital-Related Costs.

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

Title VI of the Social Security Amendments of 1983[10] added §1886(d) to the Act and established the inpatient prospective payment system (IPPS) 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[11] amended subsection (a)(4) of §1886 of the Act to add a last sentence which specifies that the term "operating costs of inpatient hospital services" does not include "capital-related costs (as defined by the Secretary for periods before October 1, 1986)....)" That provision was subsequently amended until finally, §4006(b) of Omnibus Budget Reconciliation Act (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 IPPS hospitals for cost reporting periods beginning in fiscal year (FY) 1992.

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[10] Pub. L. 98-21.

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

1. Depreciation.

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

> Medicare reimburses providers for the direct and indirect costs necessary to the provision of patient care, including the cost of using assets for inpatient care. Thus, depreciation of those assets has always been an allowable cost under Medicare. The allowance is computed on the depreciable basis and estimated useful life of the assets. When an asset is disposed of, no further depreciation may be taken on it. However, if a gain or loss is realized from the disposition, reimbursement for depreciation must be adjusted so that Medicare pays the actual cost the provider incurred in using the asset for patient care.[12]

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

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

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

> (a) *General rule*. Capital related costs … are limited to:
> (1) Net depreciation expense as determined under §§ 413.134, 413.144, and 413.149, adjusted by gains and losses realized from

[12] 44 Fed. Reg. 3980 (Jan. 19, 1979).

> 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 1976 proposed amendments to the regulation clarifying and expanding existing policy on the recognition of gains and losses, 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.[13]

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. [14] (Emphasis added.)

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

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

[13] 41 Fed. Reg. 35197 (Aug. 1976) "Principles of Reimbursement for Provider Costs: Depreciation: Allowance for the Depreciation Based on Asset Costs." (Proposed rule.)

[14] 44 Fed. Reg. 3980 (1979), "Principles of Reimbursement for Provider Costs."(Final rule.)

> the undepreciated basis of the asset permitted under the program. The treatment of the gain or loss depends upon the manner of disposition of the asset, as specified in paragraphs (f)(2) through (6) of this section ….(Emphasis added.)

The method of disposal of assets set forth at paragraph (f)(2) through (6) is set forth 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, § 104.24 of the Provider Reimbursement Manual (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.[15]

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

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

Paragraph (f)(3) addresses gains or losses realized from sales within one year after the provider terminates from the program, while 42 C.F.R. § 413.134(f)(4) addresses

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

exchange, trade-in, or donation,[16] 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 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,[17] the new owner in the same transaction is interested in the determination of when Medicare will allow the revaluation of depreciation for purposes of calculating the new owner's depreciation expense.

This latter issue, on the revaluation of assets, was the subject of significant litigation for the Medicare program regarding complex transaction and resulted in agency rulemaking on the subject. In response to litigation, the regulations at 42 C.F.R. §413.134(l)(1996)[18] were promulgated to address longstanding Medicare policy regarding depreciable assets exchanged for capital stock, statutory mergers and consolidation. Concerning the valuation of assets, the regulation states that:

> (l) *Transactions involving provider's capital stock*—(1) *Acquisition of capital stock of a provider*. If the capital stock of a provider is acquired, the provider's assets may not be revalued. For example, if Corporation A purchases the capital stock of Corporation B, the provider, Corporation B continues to be the provider after the purchase and Corporation A is merely the stockholder. Corporation B's assets may not be revalued.

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[16] A donation is defined in 42 C.F.R. § 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.

[17] 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.

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

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

(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….

(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…. Under these circumstances, at the time of the merger the transaction is one between related parties and is not a basis for revaluation of the provider's assets.

B. Related Organizations

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

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

(2) *Common ownership*. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

> (3) *Control*. Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

Consistent with the Act and the regulations, the above principles are set forth in the Provider Reimbursement Manual (PRM), which provides guidelines and policies to implement Medicare regulations for determining the reasonable cost of provider services. In determining whether the parties to a transaction are related, the PRM at § 1004, et seq., establishes that the tests of common ownership and control are to be applied separately, based on the facts and circumstances in each case. With respect to common ownership, the PRM at § 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).[19]

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

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

The related party organization was further explained in HCFA Ruling 80-4 which adopted the Eighth Circuit Court of Appeals' decision in Medical Center of Independence v. Harris, 628 F.2d 1113 (8th Cir. 1980).[20] The Ruling pointed out

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

[20] In Medical Center of Independence v. Harris, supra, the court held that a medical center and a management corporation from which it leased and operated a hospital facility were related organizations within the meaning of 42 C.F.R. §413.17, where the management corporation had purchased the assets of the hospital and had

that the applicability of the related organization rule is not necessarily determined by the absence of a relationship between the parties prior to their initial contracting, although those factors are to be considered. The applicability of the rule is determined by also considering the relationship between the parties according to the rights created by their contract. The terms of the contracts and events which occurred subsequent to the execution of the contract in that case had the effect of placing the provider under the control of the supplier.

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

1. Program Memorandum A-00-76.

To clarify the application of 42 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 than 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 A-00-76 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

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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.

related organization principles of 42 C.F.R. § 413.17, CMS stated that consideration must be given to whether the composition of the new board of directors, or other governing body and/or management team include significant representation from the previous board or management team. If that is the case, no real change of control of the assets has occurred and no gain and loss may be recognized as a result of the transaction. This PM A-00-76 recognized that, inter alia, certain relationships formed as a result of the consolidation of two entities constituted a related party transaction for which a loss on the disposal of assets could not be recognized. The PM A-00-76 stressed that "between two or more corporations that are unrelated" should include the relationship between the constituent hospitals and the surviving or consolidating entity. Consequently, the PM A-00-76 states that:

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

The PM A-00-76 stated that the term "significant," as used in PM A-00-76 has the same meaning as the term "significant" or "significantly," in the regulations at 42 C.F.R. § 413.17 and the PRM at Chapter 10. Important considerations in this regard include that the determination of common control is subjective; each situation stands on its own merits and unique facts; a finding of common control does not require 50 percent or more representation; there is no need to look behind the numbers to see if control is actually being exercised, rather the mere potential to control is sufficient.

In addition, PM A-00-76 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 A-00-76 further explained that, in evaluating whether a *bona fide* sale has occurred with respect to mergers or consolidation between or among non-profits entities, a comparison of the sale price with the fair market value of the assets is a required element of the analysis. A large disparity between the sales price and the fair market value of the assets sold indicates the lack 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[21] was applied as early as 1977 by the agency in evaluating whether accelerated depreciation would be recaptured. The agency decided that "when the termination of the provider agreement results from a transaction between related organizations and the successor provider remains in the health insurance program and its asset bases are the same as those of the terminated providers, health insurances reimbursement is equitable to all parties." Thus, the depreciation recovery provisions would not be applied.[22] 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.[23] Thus, this 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 HCFA Ruling 80-4.

This interpretation, that "between related organizations" must include an examination of all parties to the transaction, both before and after, is also consistent with the reality of a transaction involving the 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 individuals 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

[21] Originally codified at 42 C.F.R. § 405.427.
[22] 42 Fed. Reg. 45897 (Sept. 15, 1977).
[23] 42 Fed. Reg. 45897, 45898 (Sept. 15, 1977) (Recovery of excess cost resulting from the use of accelerated depreciation when termination of provider agreement results from transaction between related organizations).

> Medicare depreciable assets to determine whether the transfer involved a related party transaction.[24]

Therefore, in determining whether a provider will be reimbursed for depreciation expenses under Medicare, the Administrator finds that CMS applies a two-prong test. The first question is whether the parities are "related parties" or "unrelated parties" under the Medicare regulations. If the parties are related, they cannot engage in a *bona fide* sale and the analysis ends. If the parties are unrelated, however, the second question is whether the parties engaged in a *bona fide* sale. If the parties engaged in a *bona fide* sale, then a reimbursement for adjusted depreciation cost is proper.

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

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

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

Among the various types of provider structures and transactions recognized by Medicare are mergers, consolidations, and corporate reorganizations at § 4502. Section 4502.6 describes a statutory merger as the combination of two or more corporations pursuant to the law of the State involved, with one of the corporations surviving the transaction. Medicare permits a revaluation of the assets acquired in a statutory merger between unrelated parties, when the surviving corporation is a provider. If the surviving corporation is a provider or a related organization to the provider – such as a chain home office, the assets acquired can be revaluated. However, the merger of a non-provider corporation into a provider corporation is not

[24] Program Memorandum A-00-76 at p.3.

a change in ownership for the provider corporation and as such does not result in the revaluation of the assets of the provider corporation.

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

Section 4508.11 of the Intermediary Manual,[25] in addressing stock corporations states that, Medicare program policy places reliance on the generally accepted accounting principles or GAAP, as expressed in Accounting Principles Bulletin (APB) No. 16 in the reevaluation of assets and gain/loss computation processes for Medicare reimbursement purposes. While in certain areas, Medicare program policy deviates from that set forth in GAAP,[26] 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.[27]

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.

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[25] Section 4504.1 states that: "[W]here 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."

[26] 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).

[27] Financial Accounting Standards Board (FASB) No. 141 superseded APB No. 16 effective June 2001. However, at the present, not-for-profit (NFP) organizations are excluded from the scope of FASB No. 141.

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

This policy of not recognizing a gain or loss when the transaction is between related parties, whether it constitutes a reorganization or consolidation, is also consistent with Internal Revenue Service (IRS) rules on the non-recognition of a gain or loss when a statutory reorganization has been determined to have occurred. Relevant to this case, while the Medicare rules may diverge from IRS rules and Medicare policy is not bound by IRS policy, IRS policy often reflects rationale underlying the establishment of similar policies under Medicare.[28] 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.[29]

Under IRS rules, some consolidations are considered statutory reorganizations and subject to the non-recognition of a gain or loss. The terms reorganization and consolidation are not mutually exclusive terms under IRS rules. Medicare policy similarly indicates that they are not mutually exclusive terms under Medicare rules. That is, consolidations and mergers may in fact constitute in essence, reorganizations and reorganizations may involve more than one corporation.[30] For example, a consolidation where the predecessor corporation board continues significant control in the new corporation board is treated the same as a reorganization for Medicare reimbursement purposes and no gain or loss is recognized. However, for example, where the predecessor corporation board does not continue significant control in the new corporation board, a gain or loss will be recognized for Medicare reimbursement purposes.

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[28] See, e. g., Guernsey v. Shalala, 514 U.S. 1232 (1995), analogizing Medicare rules to IRS rules in citing to Thor Power Tools v. Commissioner, 439 U.S. 522 (1979).

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

[30] See also Black's Law Dictionary definition of a reorganization used interchangeably with merger and consolidation("A reorganization that involves a merger or consolidation under a specific State statute.")

Similar to Medicare rules, the IRS does not allow the recognition of the gain or loss when there is a reorganization, inter alia, because no gain or loss has in fact 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.[31] (Emphasis added.)

Similarly, the courts have stated that the underlying purpose of the IRS provisions that find no gain or loss when there is a reorganization was twofold: "1) to relieve certain types of corporate reorganizations from taxation which seemed oppressively premature and 2) to prevent taxpayer's from taking losses on account of wash sales and other fictitious exchanges."[32] 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."[33]

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[31] *Commissioners of IRS v. Webster Estates*, 131 F. 2d 426, 429 (2nd Cir.1942), citing *Helvering v. Schoellkopf*, 100 F. 2d 415 (2nd Cir. 1938). 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).

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

[33] *Paulsen ET UX v. Commissioner*, 469 U.S. 131 (9th Cir. 1985) citing *Southwest Natural Gas Co. v. Commissioner*, 189 F. 2d 332, 334 (5th Cir. 1951), cert. denied, 342 U.S. 860 (1951) (quoting *Commissioner v. Gilmore's Estate*, 130 F. 2d 791, 794 (3rd Cir. 1942)).

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. 3d 976 (9th Cir. 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, or consolidation between related parties, is to avoid the payment of costs not actually incurred by the parties. An overarching principle applicable under the Medicare statute and regulation, with which all reasonable cost regulations must be in accord, is the principle that Medicare will only share in costs actually incurred by the provider. Consistent with IRS rules which recognize that no cost has been incurred under the foregoing facts, Medicare similarly does not find that the provider has incurred an actual cost for purposes of Medicare reimbursement under such facts.

II. Finding of Facts and Conclusion of Law.

Applying the statute, regulations, PRM and CMS policy to the fact of this case, 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.

First, the Administrator notes that the Intermediary compared the Board of Directors of the Provider prior to the transaction to the Board of Directors of the surviving entity and concluded that there was no significant influence of the Provider on the surviving entity. The Administrator observes that the Agreement provided that the Provider's Board of Trustees would serve as an "other body" as that term is defined in the Pennsylvania Nonprofit Corporation Law.[34] The Agreement provided that the

[34] Provider's Exhibits P-1 p.2 §2.1. Three representatives of the Provider's "other body" were elected to the Board of St. Luke's.

Provider's existing trustees would be elected to the newly constituted "other body" upon completion of the Agreement, each for a term of one year and that the operating polices and procedures, along with recommendations for medical staff appointment quality improvement oversight and accreditation compliance was delegated to the Provider's "other body" subject to St. Luke's review and comment.[35] Consequently, the record indicates that, to a large part, the merger involved the continuation of the former governing Board of Trustees within the larger framework of the surviving entities health care delivery system. However, because of the Intermediary's position, the Board and the parties did not address the related party issue. While a *bona fide* sale contemplates an arm's length transaction, between unrelated parties, the Administrator finds that the related party issue need not be decided at this time in order to determine whether any gain or loss can to be recognized in this case.

Instead, consistent with 42 C.F.R. 413.134(f)(2) and as outlined in PM A-00-76 and PRM § 104.24, in evaluating whether a *bona fide* sale has occurred with respect to a merger or consolidation between or among nonprofit entities, a comparison of the sale price with the fair market value of the assets acquired is also required. A large disparity between the sale price (consideration) and the fair market value (FMV) of the assets sold 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.

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[35] Id.

In this case, the record shows that assets were transferred from the Provider to St. Luke's for the assumption of liabilities totaling $4,848,188.[36] The record further shows that no appraisal of the Provider's assets had been conducted (before or after the merger) to determine their FMV.[37] The record shows that the Provider's net book value of its depreciable assets was approximately $25 million with non-depreciable assets totaling approximately $13 million.[38] Further, the surviving entity treated the transaction as a "pooling of interest."[39] The Administrator's finds that these facts indicate the lack of reasonable consideration and, hence, the lack of a *bona fide* sale.

The Administrator notes that, in evaluating whether a *bona fide* sale has occurred, PM-A-00-76 explained that a comparison of the sales price with the FMV of the assets was a required aspect of the analysis. The record shows that no appraisal was

[36] Supra n. 6.
[37] Tr. at 27 and 261.
[38] Provider's Exhibit P-93.

Non- Depreciable Assets		**Depreciable Assets**	
Current Assets	$5,805,118	Parking Lot	$554,463
Non-Current Assets			
(Long Term Investments)	$2,686,549	Building and Improvements	$6,764,448
Land	$2,423,081	Fixed Equipment	$1,295,188
Other Assets	$164,063	Moveable Equipment	
$3,437,305			
Construction in Progress	$2,041,283	Total Depreciable Assets	$12,051,404
Total Non-Dep. Assets	$13,120,094	Other Adjustments:	
		Non-Allowable Offset	$(232,917)
		Other Adjustment:	
		Pre-Medicare Assets	$(83,346)
		Adj. Dep. Assets	$11,735,141

[39] Intermediary's Exhibit I-22, p. 6. Report of Independent Accountants on Financial Statements. "Effective January 1, 1997, the net assets of Allentown Osteopathic Medical Center (Allentown Medical Center), a nonprofit tax-exempt acute care hospital located in Allentown, Pennsylvania, were merged into St. Luke's Hospital. The merger was accounted for as a pooling of interest and, accordingly, the accompanying 1997 financial statements include the operations of Allentown Medical Center for the entire fiscal year and the 1996 financial statements have been restated to include the accounts and operations of the former Allentown Medical Center."

conducted to determine the FMV of the depreciable assets by the Provider.[40] The Administrator finds that the failure to conduct an appraisal is an indication that factors other than receiving the best price for its assets were motivations in the transaction. In particular, documents in the record that were created in the time period leading up to the merger shows that the Provider's main concerns were:

- To implement an affiliation that would enable the Provider and its physicians to effectively participate in one of the leading health care delivery systems in the area;
- To obtain sufficient capital to address resource needs, including facilities, medical staff, information systems, and program development;
- To support medical staff development and to promote greater physician-hospital integration;
- To become well-positioned for managed care.[41]

Further, the Provider's main negotiating priorities of the merger were:

- To remain a full-service acute care hospital;
- To have a formal presence in Osteopathic teaching and to continue to have Osteopathic education programs and affiliations;
- To have a pluralistic approach to medical staff, i.e., independent;
- To participate in managed care contracts.[42]

These factors reflect that, for the Provider, the value of the assets and the consideration involved in the transaction was not a factor in the merger negotiations. Therefore, the importance of these other factors in the merger transaction further supports a finding that no *bona fide* sales transaction occurred.

In addition, the record shows that the Provider's non-depreciable current assets alone were valued at $ 5.8 million and the non-current long-term investments were valued at $2.6 million, while the debt assumed was valued at $4.8 million.[43] The absence of an appraisal in the record does not prevent a finding that no reasonable consideration was paid for the depreciable assets, as the value of the current assets and non-current long term investments well exceeded the value of the debt

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[40] Provider's Exhibit P-18. Intermediary workpapers indicating that the Intermediary requested a copy of an appraisal and that the Provider explained that none was done for the transaction.

[41] Provider's Exhibit P-3.

[42] Provider's Exhibit P-4.

[43] Provider's Exhibit P-93.

assumed.[44] As a practical matter, the depreciable assets were transferred for essentially no consideration. Accordingly, 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.

As a loss cannot be allowed in this case, the Administrator does not reach the issue of how to calculate the loss. 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, especially where the value of the current assets/non-current cash and cash equivalents transferred is greater than the debt assumed. The Administrator concludes that this further supports a finding that no loss is to be calculated under the facts of this case.

[44] If the consideration received is allocated to the cash and cash equivalent assets transferred, on a dollar to dollar bases, the depreciable assets are transferred for no consideration, i.e., a donation. Where there is a donation of depreciable assets, no gain or loss is allowed.

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: **3/24/08** **/s/**

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