CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Jeanes Hospital **Provider** **vs.** **Mutual of Omaha Insurance Company** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 06/30/96** **Review of:** **PRRB Dec. No. 2003-D62** **Dated: September 26, 2003**

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

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's adjustment disallowing the Provider's claimed loss on disposal of assets due to a change of ownership was proper.[1]

[1] Section 4404 of the Balanced Budget Act of 1997 (Pub. Law 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

The Board held that the Intermediary's adjustment disallowing the loss on sale of assets was improper. The Board determined that the parties to the merger were unrelated as that term is used in 42 C.F.R § 413.134. The Board concluded that a revaluation of assets and recognition of a gain or loss was required as a result of the merger since the parties were unrelated.

In reaching this conclusion, the Board relied on its decision in North Iowa Medial Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 2000-D52, May 2000, Medicare and Medicaid Guide (CCH) 80,442, and the plain language of the regulation. The Board rejected the Intermediary's argument that, because the board of the new entity was 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, even though the directors had influence, the degree to which the influence existed was less than was needed to direct the actions of the corporation. The Board concluded that 42 C.F.R. § 413.134(l)(2)(i)(1995),[2] related to entities that were merging, not to the successive organization. The Board concluded that the very nature of the merger would likely result in some overlap of board members between the merging corporation and the surviving entity as well as a continuation of other operations and personnel of the old organizations. Thus, the Board concluded that the plain language of the regulation barred application of the related party principle to the merging parties' relationship to the new entity.

The Board rejected the Intermediary's argument that the merger was not "bona fide" and at arm's length. The Board noted that the Provider determined on its own initiative, absent of Temple's involvement, to seek an affiliation with a larger health system. In fact, the Provider discussed its sale with several health systems in the area. Therefore, the Board held that the transaction was "bona fide."

The Board also rejected the Intermediary's argument that the parties were related because they had entered into an affiliation agreement to merge about eight months before the actual merger took place. The Board determined that there was nothing in the law or regulations that indicated that a significant period of time between the affiliation agreement and the merger resulted in the transaction being between related parties. The Board concluded that a close look at the language in the affiliation agreement revealed that the covenants were only effective upon or following the effective date of the merger. Therefore, the promises were made to

---

sale or scrapping. Conforming modifications to the applicable regulation made December 1, 1997 the effective date for implementing the new rule.

[2] Originally codified at 42 CFR 405.415(*l*). Recodified at paragraph (k).

support the post-merger entity. Thus, the Board concluded that the merger transaction was at arms length.

The Board rejected the Intermediary's argument that if the merger were deemed to be a bona fide transaction done at arms-length resulting in a loss on the sale of assets, that the Provider had understated the sale price by excluding the contingent consideration of $12,000,000 given by Temple to the Provider. The Intermediary concluded that certain additional covenants were deemed to be financial covenants benefiting the Provider. The Board found that the covenants in question only became effective upon or following the effective date of the merger and that covenants only served to enhance Temple's investment since the development of a physician network served to benefit the overall Temple Health System. The Board stated that while the Provider may have been delighted to see these promises/enhancements, it had no recourse in the event that Temple reneged. As the pre-merger entity, the Provider, no longer existed, the promises were clearly made to support the post-merger entity.

Finally, the Board rejected the Intermediary contention that Generally Accepted Accounting Principles (GAAP), Accounting Principles Board Opinion 16 (APB 16) applied in this case. The Board stated that APB 16 appeared to be applicable to how a purchaser of an entity would value assets that it acquires and how to account for contingent amounts paid at a later date. Furthermore, the APB does not indicate that its principles apply, by extension, to a selling party. Second, although the general language of APB 16 talks about the inclusion of "contingent consideration," it appears to clearly contemplated that an amount determined based on a very specific formula, such as earnings over a period of time, will be paid out to the owners of the company acquired. Therefore, the Board concluded that the contingencies were to enhance the surviving entity, which had already taken on the liabilities and should not be used to calculate the sale price.

SUMMARY OF COMMENTS

CMM Comments

CMM commented requesting that the Administrator reverse the Board's decision. CMM stated that the Board incorrectly held that the parties to the merger were unrelated and thus entitled to recognize the loss incurred as a result of the merger. CMM also contended that the transaction was not a bona fide sale due to the great discrepancy between the assets and the consideration properly allocated to them. As the same legal issue was presented in Cushing, AHS 96 Related Organization Group Appeal and Meridian Hospitals Corporation Group Appeal, CMM attached and incorporated by reference those comments in those cases.

In Cushing, CMM argued that the Board incorrectly held that the Providers were entitled to claim capital reimbursement as a result of "losses" through "sales" of their facilities upon consolidation. CMM disagreed with the Board's interpretation of 42 CFR § 413.134(*l*)(3), and argued that the better reading that "between two or more corporations that are unrelated" in (*l*)(3)(i) should include the relationship between the constituent corporations and the consolidated entity. CMM reviewed the history of both (f) and (*l*) of the regulation and found that the February 5, 1979 rule was intended to clarify what constituted a transfer of stock corporations assets, and not to set forth any new policy, including any new policy on losses on depreciation, where a transfer takes place in the context of a merger or consolidation.

CMM also commented that the Board erred in finding that the Program Memorandum A-00-76 is not applicable to this case because it was contrary to the plain language of §413.134(*l*)(3)(i). CMM further argued that even if the Board is correct, the Program Memorandum nevertheless should be given force and effect. The regulation upon which the Board relies is limited to for-profit organizations. CMM commented that the Administrator should find that each Provider has failed to carry its burden that the transaction was not a related party transaction, and each Provider's claimed loss should be denied on this basis.

In AHS 96 Related Organization Group Appeal and Meridian Hospitals Corporation Group Appeal, CMM addressed the issue of a bona fide sale, noting that §104.24 of the PRM defines a bona fide sale as an arm's length transaction for reasonable consideration. In those cases, none of the hospitals' sold their depreciable assets for anything remotely approaching reasonable consideration. In fact, the record shows that two of the three hospitals transferred their depreciable assets for no consideration whatsoever. CMM noted this finding was true regardless of whether one accepts the appraisals as accurate. CMM commented that the appraisal valuations were unreasonable as they represented considerably less than the hospitals' current and monetary assets alone.

Provider's Comments

The Provider commented requesting that the Administrator affirm the Board's decision. The Provider stated that the Board correctly applied the regulations, manuals and case law when it determined that the related party rules only applied to the relationship of the parties before the transaction, i.e., pre-merger.

The Provider argued that CMS's policy outlined in Program Memorandum A-00-76 (October 19, 2000) and A-01-96 (August 7, 2001) was not consistent with the statute, regulations and manual provisions and any attempt to retroactively impose

the policy was procedurally impermissible. However, if the terms of the PM are applied, the Provider argued that the loss on sale should be recognized because "a real change of the assets" did take place. To support this position, the Provider listed several reasons which included: (1) this case involves a statutory merger, and not a consolidation; (2) that before the merger the Provider was controlled by the Philadelphia Quaker "church" (the Philadelphia Yearly Meeting of Friends) and that after the merger the Provider was owned and controlled by Temple University Health System; and (3) that any influence of the "old directors remaining on the Provider's board was greatly diminished by the fact that the Provider became a subsidiary of Temple University Health System, and the real authority was lodged at the System level, not in the individual subsidiary hospitals.

The Provider also asserted that the loss on sale should be recognized because the transaction was done at arm's length. To support this position, the Provider asserted that the Philadelphia Quaker "church" (the Philadelphia Yearly Meeting of Friends) on its own initiative, without Temple's involvement, determined that they should seek affiliation with a larger health system. Finally, the Provider argued that the merger was bona fide because reasonable consideration was received for the assets. The fact that Temple assumed the debts and liabilities of the Provider, in addition to making a one million dollar cash payment to the Philadelphia Quaker "church" (the Philadelphia Yearly Meeting of Friends) foundation demonstrated that this transaction was not one in which the assets and liabilities were simply combined on the merged or consolidated entity's books, as the PM described transactions that may not be bona fide. Moreover, the Intermediary did not challenge the reasonableness of the consideration.

Intermediary Comments

The Intermediary submitted comments requesting that the Administrator reverse the Board's decision. The Intermediary argued that the Board improperly decided that the related party principles do not apply to the post merging parities' relationship. The Intermediary maintained that the parties are related through "continuity of control" via the affiliation agreement that was signed almost eight (8) months prior to the merger agreement. In addition, the parties are related because board members of the pre-merging Provider retained a 47 percent voting position on the post-merging Provider. Furthermore, the parties are related because the Chairman and Vice Chairman of the post-merging Provider were also on the pre-merging Provider's board of directors. Thus, based on the totality of circumstances, the pre-merger entity had the power to directly, or indirectly influence or direct the policies of the new entity. Thus, the transaction involved related parties.

The Intermediary also argued that if the Provider and Temples are not related at the time of the merger, that are related under CMS 15-1§1011.1 of the PRM, which applies to all transactions.

Finally, the Intermediary argued that in the event the Provider prevailed on the issue of relatedness, the Provider incorrectly computed the sales price and resultant loss on the sale of assets by excluding the contingent consideration of $12,000,000. The Intermediary argued that GAAP ABP 16 requires that "contingent consideration which are determinable at the date of the acquisition be included in determining the cost of an acquired company and record at that date. Therefore since the $12,000,000 was determinable at the date of the merger and specifically agreed to in the affiliation agreement it should be added to the sale price. This would reduce the Provider's gross (before allocation to Medicare) claimed loss from $28,559,066 to $16,559,066. The Medicare impact would be reduced from $16,338,246 to $9,473,213.

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 CFR §413.130) for plant and fixed equipment, and for movable equipment.

Title VI of the Social Security Amendments of 1983[3] 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[4] amended subsection (a)(4) of §1886 of the Act to add a last sentence, which specifies that the term "operating costs of inpatient hospital services", does not include "capital-related costs (as defined by the Secretary for periods before October 1, 1986)...." That provision was subsequently amended until finally, §4006(b) of OBRA 1987 revised §1886(g)(1) of the Act to require the Secretary to establish a prospective payment system for the capital-related costs of PPS hospitals for cost reporting periods beginning in fiscal year (FY) 1992.

1. Depreciation.

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

[3] Pub. Law 98-21.

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

> Medicare pays the actual cost the provider incurred in using the asset for patient care.[5]

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 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. [6]

---

[5] 44 Fed. Reg. 3980 (Jan 19, 1979).

[6] 41 Fed. Reg. 35197 (August 20,1976) "Principles of Reimbursement for Provider Costs: Depreciation: Allowance for the Depreciation Based on Asset Costs." (Proposed rule.)

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

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

> *Bona fide sale or scrapping*. (i) Except as specified in paragraph (f)(3) of this section, gains and losses realized from the bona fide sale or scrapping of depreciable assets are included in the

---

[7] 44 Fed. Reg. 3980. (1979) "Principles of Reimbursement for Provider Costs."(Final rule.)

> 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. [8]

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

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

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[9] 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

---

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

[9] 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.

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,[10] the new owner in the same transaction is interested in the determination of when Medicare will allow the revaluation of depreciation for purposes of calculating the new owner's depreciation expense.

This latter issue, on the revaluation of assets, was the subject of significant litigation for the Medicare program regarding complex transaction and resulted in agency rulemaking on the subject. In response to litigation, the regulations at 42 CFR §413.134(*l*)[11] were promulgated to address longstanding Medicare policy regarding depreciable assets exchanged for capital stock, statutory mergers and consolidation. Concerning the valuation of assets, the regulation states that:

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

[10] 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.

[11] (1995) Originally codified at 42 CFR §405.415(*l*).Redesignated at 42 CFR 413.134 (k) (2002).

(i) *Statutory merger between unrelated parties*. If the statutory merge is between two or more corporations that are unrelated (as specified in §413.17), the assets of the merged corporation(s) acquired by the surviving corporation may be revalued in accordance with paragraph (g) of this section. 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

Finally, 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).[12]

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

> The owners of a 200-bed hospital convert their facility to a nonprofit corporation. The owners sell the hospital to a non-profit corporation under the direction of a board of trustees made up of former owners of the proprietary corporation. Both corporations are considered related organizations; therefore, the asset bases to the nonprofit corporations remain the same as contained in the proprietary

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

> 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).[13] The Ruling pointed out that the applicability of the related organization rule is not necessarily determined by the absence of a relationship between the parties prior to their initial contracting, although those factors are to be considered. The applicability of the rule is determined by also considering the relationship between the parties according to the rights created by their contract. The terms of the contracts and events, which occurred subsequent to the execution of the contract, in that case had the effect of placing the provider under the control of the supplier.

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

1. Program Memorandum A-00-76.

To clarify the application of 42 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,

---

[13] 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.

2000.[14] 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

---

[14] Replaced by PM-01-96 (Aug.7, 2001). The only change was the discard date.

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. 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.[15]

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

---

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

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.[16] 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.[17] Thus, the PM interpretation of the related party rules as requiring an examination of the relationship before and after the transfer of assets is consistent with early Medicare policy and HCFAR 80-4.

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

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.

---

[16] 42 Fed. Reg. 45897 (1977).

[17] 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.)

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

Among the various types of provider structures and transactions recognized by Medicare are mergers, consolidations, and corporate reorganizations at § 4502. Section 4502. 6, describes a statutory merger as the combination of two or more corporations pursuant to the laws of the state involved, with one of the corporations surviving the transaction. Medicare program policy permits a revaluation of assets acquired in a statutory merger between unrelated parties, when the surviving corporation is a provider. Notably, Medicare policy at § 4502.10 does not permit a revaluation of assets affected by a "reorganization" of a corporate structure. All such transactions are considered among or between related parties. As an example the Intermediary Manual explains that:

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

In the instance of a 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,[18] 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

[18] 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."

policy deviates from that set forth in GAAP,[19] Intermediaries are instructed to refer to the principles outlined in the CHOW manual which specify when reference to APB No. 16 is in accordance with the current Medicare policy.

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

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

This policy of not recognizing a gain or loss when the transaction is between related parties, whether it constitutes a reorganization, consolidation or merger, is also consistent with Internal Revenue Service (IRS) rules on the non-recognition of a gain or loss when a statutory reorganization has been determined to have occurred. Relevant to this case, while the Medicare rules may diverge from IRS rules and Medicare policy is not bound by IRS policy, IRS policy often reflects rationale underlying the establishment of similar policies under Medicare.[20] In

[19] 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).

[20] 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).

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.[21]

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.[22] For example, where one or both of the predecessor corporation board(s) continue significant control in the new corporation board, a merger is treated the same as a reorganization for Medicare reimbursement purposes and no gain or loss is recognized. However, for example, where one of the predecessor corporation boards does not continue significant control in the new corporation board, a gain or loss will be recognized for Medicare reimbursement purposes for that corporation.

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

---

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

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

> a continuity of interest and control accomplished [in this instance] by an exchange of stock for stock.[23] (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."[24] 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."[25]

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:

---

[23] 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).

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

[25] 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)).

> 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 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. Pursuant to the terms of an Affiliation Agreement, dated November 17, 1995, the Provider merged with Temple Central Hospital, Inc., (Temple Central), with Temple Central designated as the surviving corporation..[26] Temple Central, a Pennsylvania nonprofit corporation was formed for the purpose of merging the Provider with Temple Central, thereby acquiring the assets and liabilities of the Provider.[27] Pursuant to the Affiliation Agreement,

---

[26] The Provider's affiliates were merged into the Provider and the Provider was subsequently merged into Temple Central. The Provider's affiliates included Anna T. Jeanes Foundation, Friends Hall at Fox Chase, and J.H. Management Company.

[27] See Exhibit I-2 ("Whereas, TUHS [Temple Health] is the sole member of TCH [Temple Central-the surviving entity], a Pennsylvania nonprofit corporation formed for the purposes of merging JH [the Provider] with TCH,

the sole member (i.e., the non-profit equivalent of a stockholder) of Temple Central was Temple University Health System, Inc., (Temple Health) and the sole member of Temple Health was the University of the Commonwealth of Higher Education (University). Also included in the affiliation agreement was Temple University Hospital of which Temple Health was the sole member. The effective date of the merger was July 1, 1996. Temple Central as the surviving entity, was renamed Jeanes Hospital (hereafter referred to as the surviving entity) after the merger.

Further, the Provider's affiliates were merged into the Provider prior to the merger with Temple Central. The Provider's affiliates included Anna T. Jeanes Foundation, Friends Hall at Fox Chase, and J.H. Management Company Prior to the merger, the Provider acknowledged that it was controlled by the "Foundation" referred to as Jeanes Management System Company, and later named the Anna T. Jeanes Foundation.[28] On the effective date of the merger, Section 1.1 of the agreement provided that the board of directors of the Provider would resign and became members of the board of Jeanes System Management Company which would be renamed Anna T. Jeanes Foundation.

Section 1.3 of the agreement provided that Jeanes Management Company would receive a cash contribution in the amount of one million dollars to be used in a manner consistent with the purposes set forth in its articles of incorporation including the promotion of wellness and the support of health care delivery activities in the communities service by Jeanes Hospital. In addition, the Agreement provided, at Section 2, for Jeanes Management Company to appoint two members of the board of directors of the Temple Health and two members of board of governance of the Temple University Hospital. Section 3 of the agreement provides that Jeanes Management Company shall appoint 20 board of directors each having one vote for the entity and that Temple Health will appoint 10 of the director each having two votes.

Consistent with the affiliation agreement, the agreement and plan of merger, provided that on the effective date of the merger all the property, real, personnel and mixed and all debts due "shall be taken and deemed to be transferred to and

---

thereby acquiring the assets and liabilities of JH and its affiliates that have been merged into JH, ….."

[28] See ,e.g., Provider's Post-Hearing Brief p.5. The Provider explained that the Foundations Bylaws require that at least two-thirds of its directors be members of the Philadelphia Yearly Meeting of Friends.

vested in the surviving corporation, Temple Central. The document was entered into June 24. 1995, with the merger to be effective June 30, 1995.[29]

In addition, the Bylaw of the surviving entity, Jeanes Hospital (formerly Temple Central), provides at Article 4.1 that Temple Health will be the sole member of the surviving corporation, the (new) Jeanes Hospital. The Bylaws at Article 4.2 sets forth the reserved powers of the members.[30] In addition, Article 5.1 sets forth the general powers of the board of directors.[31] In addition, the Article 5.3 provides for the appointment of the board of director with Jeanes Management Company having the right to nominate that number of members of the board of directors with the authority to cast one less vote than a majority of the votes that all directors are entitled to cast. Article 5.11 provides that the board shall adopt annual operating and budgets subject to approval by the member, while Article 5.12 explains that "the board shall appoint and shall have the power to remove all members of the medical staff and employees connected with the corporation."(Emphasis added.) Article 5.13 explains that the board "has the duty and responsibility for the ultimate conduct of the corporation." Finally, Article 5.17 explains that one half of the voting directors nominated by the Jeanes Management System and one half of the voting directors appointed by Temple Health shall constitute a quorom.

---

[29] Exhibit P-6A..

[30] The reserved powers of the member included: 1) any dissolution or liquidation of the corporation; any merger of the corporation, any amendments to the articles of the incorporation of the corporation; any amendments to the bylaws regarding the Member, the number of directors, quorom or voting requirements; the sale pledge, lease or other transfer of the assets of the corporation other than transactions occurring in the normal course of business; any decision to merge with acquire, etc, with a medical school other than the university or the temple university hospital; deletion of any clinical programs that are needed for accreditation of the Temple University School of Medicine; the adoption of the corporation annual capital and operating budgets, the issuance or assumption of indebtedness in excess of five hundred thousand dollars by the corporation, and the execution of any contract providing for the management of the corporation.

[31] Article 5.1 states that:: "The business affairs of the corporation shall be managed by the board. In addition to the powers and authorities expressly granted by these Bylaws, the Board may exercise all powers of the corporation and do all acts and things not prohibited by applicable law by the articles of incorporation and by these bylaws."

The Provider filed a terminating Medicare cost report for the fiscal year ending June 30, 1996, which included a depreciation adjustment that recognized a loss on disposal of assets resulting from the merger. Upon audit of the cost report, the Intermediary issued a Notice of Program Reimbursement (NPR) dated May 28, 1998, denying the claimed loss.

Applying the statute, regulations, PRM and CMS policy to the facts of this case, the Administrator finds that based on a combination of factors the parties to the transaction (i.e., merger) are related through control. 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 at the surviving corporation included significant representation from the Provider's previous Board or management team. This involves determining whether former board members of the Provider had the power, to directly or indirectly, significantly to influence or direct the actions or policies of the surviving corporation. If such is the case, then no real change of control of the assets has occurred and no gain or loss will be 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.

Accordingly, in this case, the record shows that a significant number of members from the Provider's Board of Directors transferred to the surviving entity and constituted 47 percent of the voting positions of the surviving entity's Board of Directors.[32] The record also reveals that 44 percent of the non-voting Board members were former directors on the Provider's Board of Directors and now designated as ex officio of the surviving entity.[33] The record shows that the Chairman and Vice Chairman of the surviving entity were also on the Provider's Board of Directors. Furthermore, the record shows that senior officers of the Provider continued as officers at the surviving entity and became the President/CEO, Treasurer/CFO and Secretary.[34]

In this case, the Administrator finds that the common former Board Members enabled the Provider to significantly influence or direct the actions or policies of the surviving corporation and showed a continuity of control between the

[32] See Exhibit I-3.

[33] See Exhibit I-3.

[34] See Exhibit I-3.

Provider and the surviving corporation. Thus, based on the totality of the circumstances, the Administrator finds that the Provider is related through continuity of control with the surviving corporation.

In addition, the continuation of the Provider's name, programs and the development of new programs, which mirror the Provider's purpose and mission, are also significant and reflect a continuity of control. The continuation of the Provider's mission for at least five years; the continuation of a favorable land lease for one dollar per year, and the continued receipt of interest income on Trust funds point to a related party transaction. Therefore, since the parties to the transaction are related according to 42 C.F.R. § 413.17, the loss on the disposal of assets cannot be recognized under Medicare.

However, the Administrator notes that the Provider argues that the representation on the board of directors by former members of the Provider is diminished by the fact that the board has limited powers. The Provider argues that the sole member of the surviving corporation Temple Health has reserved significant powers and that these powers were further strengthened and the board members' powers further weakened as shown in memorandums issued in 1997 and 1998 showing divesture of certain spending powers and management tools.[35]

While the Administrator recognizes that there were certain restrictions to the board of directors powers several years after the transaction, those same restrictions did not appear to be in place or authorized under the Corporation Bylaws at the time of the merger transaction. Further, the Provider overlooks significant powers that were vested in the board of directors. The board had the power to manage the corporation; the board had the power to exercise all powers of the corporation and do all acts and things that are not prohibited by applicable law, the article of incorporation or by the Bylaws; the board could adopt budgets and authorize bond expenditures of up to $500,000; the board could also remove medical staff and corporation employees. Finally, the Bylaws vested in the board of directors the duty and responsibility for the ultimate conduct of the corporation. That is, regardless of where the powers were ultimately vested, the board

[35] The Bylaws of the surviving corporation does provide that Jeanes Management System would have two members of the board of directors of the sole member, Temple Health, but the significance of this, if any, cannot be determined based on this record which lacks pertinent documentation relating to Temple Health. The Bylaws also provide that Jeanes Management System would have two members on the board of governance of the Temple University Hospital, the principle medical school and a subsidiary of Temple Health.

members would be held responsible for the conduct of the corporation. Consequently, the Administrator finds that the board of directors of the corporation at the time of the merger retained significant powers over the operation of the surviving entity.

The Administrator also notes that the Board made several findings regarding the interaction of the various regulations on 42 C.F.R. § 413.134(*l*). The Board held that the general rules on the disposal of assets and related parties were not controlling over the specific language of paragraph (*l*) regarding merger. While the general related party rules could be interpreted to require an examination of the relationship between the merging entities, the Board found that this interpretation was rejected by the Secretary.

However, the Administrator finds that, as the issue under appeal involves the recognition of depreciation lost on the transfer of assets from a merger between non-profit entities, he cannot limit his review to 42 C.F.R. § 412.134(l). Paragraph (l) was drafted specifically to address the revaluation of assets for proprietary corporations that merger or consolidate, while paragraph (f) specifically addresses circumstances under which a gain or loss will be recognized. Paragraph (l) did not modify or limit the general related party rules at 42 C.F.R. § 413.17 and does not address or modify the criteria for the recognition of gains or losses at paragraph 42 C.F.R. § 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) and thus must be interpreted consistent with those provisions.[36]

---

[36] See e.g., 44 Fed. Reg. 6912 (Feb 5, 1979)("Although no single provision of the Medicare regulations explicitly set forth these policies, our position has been based on the interaction of three regulations: 42 CFR 405.415, concerning the allowance for depreciation based on asset costs; 42 CFR 405.427, concerning cost related organizations; and 42 CFR 405.626, concerning change of ownership. We continue to believe that our interpretation and application of these regulations are reasonable and consistent with our statutory mandate to determine the scope of the reasonable costs for Medicare providers." (Emphasis added.)); 42 Fed. Reg. 6912 ("Our intent is not to change existing Medicare policy, but merely to state explicitly in the Code of Federal Regulations that which has been stated in the past in less formal settings."); 42 Fed. Reg. 17486(1977)("The proposed revision of paragraph (l) 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

As noted above, since the parties to this transaction are related, the Administrator further finds that the transaction was not consummated through an arm's length transaction. The Provider argues that it sought out merger with several institutions before its approval of the Temple merger. However, the record shows that the payment of consideration above the assumption of debt was not a factor in the search for a merger partner. Furthermore, the Administrator finds that the amount of consideration received for the Provider's depreciable assets reflects that lack of motivation. The Administrator finds that the assumption of debt and one million in cash consideration were transferred for, inter alia, the Provider's depreciable assets. This resulted in assets with a net book value of $98,708,000 being transferred for a total of $69,214,000 in consideration, which does not, in the Administrator's view, support a finding that the transaction was an arm's length transaction.[37] 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 for the recognition of a loss on the disposal of assets.

Finally, as a loss cannot be allowed in this case, the Administrator does not reach the issue of how to calculate the loss.[38] However, the issue of calculating a loss

---

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.")

[37] Intermediary's Exhibit I-17. Further the Provider's calculation shows that the net book value of the depreciable assets as approximately $50-54 million, compared to the allocated sale price of approximately $26- 29 million. The Administrator notes that the Provider submitted an appraisal (Exhibit P-36) that found the worth of the depreciable assets to be $30,100,000. However, the appraisal appears to have been submitted pursuant to the post-hearing brief and therefore was not analyzed, inter alia, under the criteria set forth at section 4505 of the CHOW and other pertinent provisions.

[38] The Administrator recognizes that the Intermediary raised the issue as to whether or not the Provider has understated the sale price by not including the commitments of $12,000,000, thereby, miscalculating the amount of the loss. However, as the Administrator does not find that the Provider meets the criteria for the allowance of a loss, this issue need not be addressed. The Administrator does note that the Board did not address whether the Provider's parent foundation, as a party to the merger agreement and intended recipient of any of

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. The Administrator concludes that this further supports a finding that no loss is to be calculated under the facts of this case.

In this case, there was minimum new consideration that exchanged hands as a result of the transfer of assets. Instead, the Provider's debt (plus one million dollars) was assumed by the new corporation. In previous cases, the Board has recognized that expert witnesses were not "able to articulate how the financing of a consolidation under the state law formula of transferring all assets and liabilities produces a better gauge of consumption of depreciable assets for Medicare services than the estimate under straight line depreciation." In these case, if one were to assume that the assumption of liabilities would be the basis for any loss, the Board recognized that a well run and performing hospital corporation may well experience a greater "loss" on depreciable assets, than the poor performing hospital corporation. Similarly, in this case, the Administrator finds that there is an obvious flaw in finding this consolidation constituted an event requiring application of a loss methodology that is applied to bona fide sales, where, in fact, there has not been a bona fide sale.[39]

Consequently, the Administrator finds that, not only was the transaction between related parties, but that there was no bona fide sale as required under 42 CFR §413.134(f) and that the Providers failed to meet any of the other criteria of paragraph (f) that would allow the calculation of a "loss on consolidation."

---

the "consideration" negotiated, would have recourse for failure to perform the covenants, as it continued to exist after the merger.

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

DECISION

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

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

Date: 11/25/03 /s/

Leslie V. Norwalk, Esq.
Acting Deputy Administrator
Centers For Medicare & Medicaid Services