CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Harrisburg Hospital/Seidle Memorial Hospital **Provider**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: December 31, 1995**
vs.	
Blue Cross Blue Shield Association/ Veritus Medicare Services (n/k/a Highmark Medicare Services) **Intermediary**	**Review of:** **PRRB Dec. No. 2008-D39** **Dated: September 26, 2008**

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

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's adjustments to the Provider's[1] cost report that disallowed the loss on disposal of depreciable assets through consolidation were proper.

[1] Harrisburg Hospital was a non-profit, acute care hospital and Seidle Memorial Hospital was a non-profit skilled nursing facility that became part of Harrisburg Hospital. The facilities operated under a single license and were assigned a single Medicare provider number. Hence, the facilities are considered a single provider for purposes of this appeal.

The Board held that the Intermediary's adjustments disallowing the Provider's claimed loss on the disposal of assets due to a change of ownership resulting from a consolidation were contrary to the regulatory requirements of 42 CFR §413.134(l)(3)(i). The Board remanded the issue to the Intermediary for the proper calculation of the loss, pursuant to the governing regulatory and manual provisions and the Board found that no consideration (liabilities assumed) should be allocated to the intangible assets of medical records and assembled workforce.

The Board held that the Provider was unrelated to Polyclinic Medical Center (the pre-existing consolidating entity) prior to the consolidation as that term is defined and applied under the regulatory provisions of 42 CFR §§413.17 and 413.134. The Board addressed the two fundamental arguments offered by the Intermediary in its denial of the Provider's claim. First, the Board stated that, contrary to the Intermediary's arguments, the consolidation was not between related parties. The Board noted that it is undisputed that the Provider and Polyclinic were not related to one another prior to the consolidation. The Board reasoned that the text at 42 CFR §413.134(l)(3)(i) specifically states that "if the consolidation is between two or more corporations that are unrelated…" and is unambiguous in its meaning that the related party concept will be applied to the entities that are consolidating as they existed prior to the transaction. The Board acknowledged that CMS Program Memorandum (PM) A-00-76 (October 2000), stated that, to determine whether parties are related, the focus of the inquiry is whether significant ownership or control exists between a corporation transferring assets and the corporation receiving them. However, the Board found that the plain language of the consolidation regulation bars the application of the related party principle to the consolidating parties' relationship to the surviving entity. The Board also argued that the history of the regulation provides more compelling evidence of the Secretary's intent to look to only to the pre-transaction relationship for application of the related party principle.

The Board also pointed out that the final regulation, adopted in 1979, rejected an earlier proposed version which treated all consolidations as transactions between related parties, and instead, opted for language permitting revaluation of assets where consolidating parties were unrelated. Moreover, the Board noted that interpretive guidelines published in Medicare's Part A Intermediary Manual (CMS Pub. 13-4) §4502.7, published prior to CMS PM A-00-76, also permitted revaluation of assets for consolidations between unrelated parties. The Board further maintained that two letters from CMS officials[2] supported this position.

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[2] *See* Provider's Position Paper, Exhibits P-53 and P–18. (May 11, 1987 letter from HCFA's Director of the Division of Payment and Reporting Policy, Office of

Next, the Board found that the consolidation between the Provider and Polyclinic Medical Center, resulting in the formation of Pinnacle Hospitals was a bona fide transaction under Pennsylvania corporation law. The Board argued that the transaction consolidated three hospital corporations into one new entity, with the pre-existing entities ceasing to exist. The Board rejected the "continuity of control" doctrine embodied in PM A-00-76 (October 2000), and found that such an interpretation of the related party regulation is not only inconsistent with the regulation governing consolidations, but ignores the very nature of a consolidation. The Board reasoned that a combination of entities would likely result in some overlap of membership on the boards of trustees of the consolidating corporation and the new entity, as well as a continuation of other operations and personnel of the old organizations. The Board concluded that the fact that this occurs does not disqualify a consolidation from revaluation and recognition of any gain or loss under 42 CFR § 413.134(l).

The Board acknowledged the Administrator's reversal of its decision in *Cardinal Cushing Hospital/Goddard Memorial Hospital*,[3] based upon the relatedness of the consolidating corporations to the new entity. The Board noted that the Administrator, in that decision, concluded that the record contained compelling evidence of the relatedness of the consolidating corporations and the newly established corporation.[4] However, the Board stated that, as the case under appeal concerns the recognition of losses on the transfer of assets, the Board cannot limit its review only to the related party rules, the transaction at issue must be viewed in light of specific consolidation regulation at 42 CFR § 413.134(l)(3).

The Board was persuaded that the use of the term "bona fide transaction" in the preamble of the regulation's promulgation versus "bona fide sale" indicated that the Secretary did not consider mergers and consolidations as sales and was only

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Reimbursement Policy, and August 24, 1994 letter from the Director, Office of Payment Policy, Bureau of Policy Development).

[3] *See Cardinal Cushing Hospital/Goddard Memorial Hospital*, PRRB Dec. No. 2003-D6 (Admin. rev., Nov. 27, 2002).

[4] The Board also cited a recent Tenth Circuit Court of Appeals decision, *Via Christi v. Leavitt*, 509 F.3d 1259. The Court found the Secretary's attempt to apply the continuity of control concept unsupportable given the explicit language of the consolidation regulation. However, the court agreed with the Intermediary's position that, even if a gain or loss is authorized by the regulation, the Providers nevertheless have an additional burden of showing that the transaction constitutes a "bona fide sale."

concerned that the transaction was not a sham.[5] Thus, the Board agreed with the Provider's stipulation that this was a "bona fide transaction." The Board has consistently rejected the position that requires the transaction to be a "bona fide sale," finding instead that when the regulation was amended to add 42 CFR §413.134(l), it expanded the disposition methods listed in section (f) to include consolidations and mergers; it did not require fitting consolidations and mergers into one of the disposition methods already listed. The Board reasoned that requiring "bargaining" between the old and new entity to be "arm's length" would effectively nullify the regulation's directive to permit revaluation where unrelated parties consolidate. The Board noted that the record is clear that the Provider was not interested in selling their assets. Rather, the Provider saw a need to establish a partnership with Polyclinic Medical Center to assure their continued operation.

The Board found, as it did in *Cardinal Cushing Hospital*, *supra*, that the explicit language in the consolidation regulations severely limits the application of the related party regulations to consolidations. The Board contends that nothing in the Administrator's reversal of *Cardinal Cushing Hospital* reconciles the competing principles expressed in the two regulations. The Board noted that the Administrator's decision cites Internal Revenue Service (IRS) precedent for the proposition that a consolidation is a mere reorganization and, thus, a gain or loss is not recognized for IRS purposes. The Board observed that all consolidations and mergers are to some extent a form of reorganization as that term may be commonly used. The Board noted that parties stipulated that the transaction at issue was not a reorganization under IRS principles or State law.

Finally, the Board noted the Provider's argument that the liabilities assumed by the new consolidated hospital entity, Pinnacle Hospitals, for transfer of the assets was the "consideration" that is to be used as the acquisition cost. The Provider further contended that the acquisition cost resulted from an arm's-length transaction between unrelated consolidating parties and, thus, reflects the "fair market" value of the transaction. The Provider concluded that the revaluation of the assets and calculation of the loss was purely a function of allocating the consideration (liabilities assumed) among all of the assets transferred.

The Provider, though consolidated under a new corporate structure, continued providing many of the same services using the same facilities and, to some extent, using the same personnel. The Board recognized that, if this transaction had been structured as a sale with the old providers creating their own buyer and dictating the terms, a loss would not have been recognized because it would have been treated as

[5] The Board noted that the regulation had a specific section entitled "bona fide sale or scrapping." 42 CFR § 405.415(f)(2)(1979).

being between related parties. The Board noted that related party rules and regulations prohibit "self-dealing" to obtain reimbursement from the Medicare program.

The Board acknowledged that there was no "disposition" of assets as that term is used in the specific regulatory provision addressing gains and losses on disposal of assets. However, the Board concluded that the consolidation regulation, as written, does not require the application of the principles concerning "bona fide sale" and "arm's-length bargaining" to the relationship between the consolidating hospitals and their successor. Given the explicit limitation on the application of the related party principle and CMS' longstanding interpretation that the regulation addressing consolidations applies to non-stock company transaction, the Board found no authority in the regulations or the guidelines in effect at the time of the transaction to permit motivations unique to non-profits to be a determining factor in the reimbursement treatment.

The Board noted that, when ownership of a depreciable asset changes, cost is measured by changes in fair market value, typically reflected in the consideration paid for those assets. However, in a consolidation, "consideration" terms are dictated by operation of law and there is typically no "consideration" other than the amount of liability assumed. The Board noted that it was nevertheless bound by the regulatory directive to adjust depreciation, when unrelated Medicare providers engage in a consolidation.

The Board concluded that evidence of a changing healthcare environment, combined with the lack of a market for providers' facilities, is persuasive that the Provider incurred a genuine economic loss of value of their depreciable assets. The Board further concluded that, the process of finding a suitable consolidation partner requires arms-length evaluation and bargaining similar to a traditional sale. The Board added that the process may be more imprecise in producing fair market value. Further, the Board noted that the Intermediary Manual supports this view, as reflected in its incorporation of Accounting Principles Bulletin No. 16 (APB No. 16) of generally accepted accounting principles (GAAP), which discusses the revaluation of assets and the gain/loss computation process for various types of business combinations. The Board concluded that APB No. 6, as well as two CMS letters,[6] supported the view of treating assumption of liabilities as the fair market value in business

[6] *See* Provider's Position Paper, Exhibits P-53 and P–18. (May 11, 1987 letter from HCFA's Director of the Division of Payment and Reporting Policy, Office of Reimbursement Policy, and August 24, 1994 letter from the Director, Office of Payment Policy, Bureau of Policy Development).

combinations, and that a gain or loss is required to be determined under 42 CFR § 413.134(f).

With regard to the calculation of loss, the Board also found that the Provider agreed that the loss calculation should be based upon the proportionate value methodology prescribed by 42 CFR §413.134(f)(2)(iv). Pursuant to this methodology, the consideration is the amount of assumed liabilities and is allocated among all of the assets transferred based upon the relationship of each asset's fair market value to the total fair market value of all of the entity's assets in the aggregate.

The Board rejected the Provider's assertion that part of the total consideration received should include the value of their medical records and assembled workforce. The Board found that no consideration, or liabilities assumed, should be allocated to these items to determine the Provider's loss. The Board reasoned that medical records and assembled workforce are intangible assets that have going concern value and only exist in sales transactions where the sale proceeds exceed the value of the land and other tangible assets involved in the purchase. The Board noted that the proceeds at issue in this case did not exceed the value of the tangible assets and, therefore, medical records and assembled workforce are not found to exist.[7]

The Board went on to explain that, although it adheres to its decision that a bona fide sale is not required, it recognized that courts in other cases have found the Secretary's position supportable, and addressed the application of that principle to the facts in the case. Based on the regulation at 42 CFR § 413.134(b)(2), two criteria must be met for a bona fide sale. First, there must be bargaining between a well-informed buyer and seller. Second, there is an assumption that the results of the bargaining would approximate fair market value. Based upon this bona fide sale transaction definition, the Board found that there was no bargaining between the buyer and seller, as in a consolidation there is no buyer and seller. Rather, each of the consolidating parties is in essence both a "seller" and a "buyer," thus, negating the concept of arm's-length bargaining. The Board also found that the consideration received in the consolidation

[7] The Board relied upon Paragraph 39 of Statement No. 141 issued by the Financial Accounting Standards Board (FASB), explaining that intangible assets that do not arise from contractual or other legal rights will be recognized as assets apart from goodwill only if they are capable of being separated from the acquired entity and sold. The Board did not find that medical records and assembled workforce could be separated and sold apart from the Providers' operation. Paragraph 39 continues to state that "an assembled workforce shall not be recognized as an intangible asset apart from goodwill." The Board found that medical records shared the same fundamental characteristics as an assembled workforce.

transaction was significantly less than the fair market value of the assets at the time of the transaction.

In conclusion, the Board held that the Intermediary's adjustments disallowing the Provider's claimed loss on the disposal of assets due to a change of ownership resulting from a consolidation were contrary to the regulatory requirements of 42 CFR §413.134(l)(3)(i). The Board remanded the issue to the Intermediary for the proper calculation of the loss pursuant to the governing regulatory and manual provisions and consistent with the Board's finding that no consideration (liabilities assumed) should be allocated to the intangible assets of medical records and assembled workforce.

SUMMARY OF COMMENTS

CMM Comments

CMM commented requesting that the Administrator reverse the Board's decision. CMM argued that the Board made several errors in its decision. First, the Board incorrectly found that, pursuant to 42 CFR § 413.134(l)(2), the Intermediary could only examine whether the parties were related prior to the consolidation transaction. Consequently, the Board rejected the Intermediary's argument that there was a continuity of control that resulted in the parties to the consolidation being related. CMM maintained that the courts that have addressed the issue and have deferred to CMS' reasonable interpretation that 42 CFR §413.134(l)(2) must be read together with 42 CFR §413.17 and that the related party doctrine applies to relationships created by the transaction at issue, as well as pre-existing relationships. CMM noted that PM A-00-76 clarified how 42 CFR §413.134(l) applies to mergers and consolidations involving non-profit providers. CMM noted that one important factor is 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. In the instant case, CMM argued that seven out of twenty-two members of Pinnacle Health Hospital's Board of Directors (consolidated entity) were on the Provider's board.

Second, CMM stated that the Provider did not receive "reasonable consideration" for their depreciable assets. Thus, CMM concluded that the transaction was not a bona fide sale and the Intermediary's disallowance should have been upheld.

Provider's Comments

The Provider commented, requesting that the Administrator modify the Board's determination prohibiting assignment of consideration to medical records and

assembled workforce. The Provider supported the Board's determination that the loss at issue was reimbursable and consistent with the pertinent laws, regulations, and policies that require recognition of a loss incurred from a consolidation between unrelated parties. The Provider noted that the Board correctly determined that a consolidation is not required to satisfy requirements of a bona fide sale. However, the Provider explained "in the interest of judicial economy" the Board addressed the application of the bona fide sale requirements to the applicable facts and found that the transaction was not a bona fide sale. The Provider argued that the Board was incorrect, and to the extent that a consolidation can be considered a "sale," the transaction was a bona fide sale, satisfying all bona fide sale requirements that were applicable at the time of the transaction, as well as the subsequently adopted reasonable consideration requirement. Thus, the Provider argued that the Intermediary's adjustment disallowing the loss claim was contrary to Medicare regulations and longstanding regulatory interpretations.

The Provider acknowledged that it agreed with the Board's decision that the loss on consolidation should be computed based on the proportionate allocation methodology, requiring allocation of consideration among assets based upon the relationship of each asset's fair market value to the total fair market value of all the assets. However, the Provider disagreed with the Board's decision that no consideration should be assigned to medical records and assembled workforce, because the total consideration did not exceed the value of the Provider's tangible assets. The Provider contended that the Medicare regulations and interpretations require assignment of consideration to all assets transferred through consolidation, including medical records and assembled workforce. The Providers also argued that the Board incorrectly relied on GAAP to reach a contrary result. The Provider noted that, even if there were an applicable GAAP policy that would preclude assignment of consideration to these assets, GAAP cannot require a result that is contrary to Medicare regulations and related interpretations.[8]

DISCUSSION

[8] The Provider argued that the Board's application of GAAP was incorrect because the Financial Accounting Standards Board (FASB) Statement 141, on which it relied, was not issued until 2001(five years after the transaction); FASB 141 does not apply to transactions involving not-for-profit corporations; FASB 141 addressed only accounting by the "acquiring entity," not the consolidated entity that ceases to exist as a result of the transaction; and FASB 141 does not preclude assignment of consideration to medical records because the asset "arises from contractual or other legal rights."

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 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 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[9] 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[10] 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

[9] Pub. L. 98-21.

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

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.

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.[11]

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:

[11] 44 Fed. Reg. 3980 (Jan. 19, 1979).

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

The regulation specifies that only certain events will result in the recognition of a gain or loss in the disposal of depreciable assets. The Secretary explained in the 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.[12]

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. [13] (Emphasis added.)

These rules have been set forth at 42 CFR § 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

[12] 41 Fed. Reg. 35197 (Aug. 1976) "Principles of Reimbursement for Provider Costs: Depreciation: Allowance for the Depreciation Based on Asset Costs." (Proposed rule.)

[13] 44 Fed. Reg. 3980 (1979), "Principles of Reimbursement for Provider Costs." (Final rule.)

> 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 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.[14]

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.

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

Paragraph (f)(3) addresses gains or losses realized from sales within one year after the provider terminates from the program, while 42 CFR § 413.134(f)(4) addresses exchange, trade-in, or donation,[15] 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,[16] 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)(1996)[17] 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

[15] A donation is defined in 42 CFR § 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.

[16] 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.

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

> Corporation A is merely the stockholder. Corporation B's assets may not be revalued.
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> (3) *Consolidation.* A consolidation is the combination of two or more corporations resulting in the creation of a new corporate entity. If at least one of the original corporations is a provider, the effect of a consolidation upon Medicare reimbursement for the provider is as follows:
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> (i) *Consolidation between unrelated parties*. If the consolidation is between two or more corporations that are unrelated (as specified in § 413.17), the assets of the provider corporation(s) may be revalued in accordance with paragraph (g) of this section.
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> (ii) *Consolidation between related parties*. If the consolidation is between two or more related corporations (as specified in § 413.17), no revaluation of provider assets is permitted. (Emphasis added.) [18]

B. Related Organizations

The regulation at 42 CFR § 413.134 references the related organization rules at 42 CFR § 413.17. The regulation at 42 CFR § 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 §

[18] *See* also 44 Fed. Reg. 6912-14 (Feb. 5, 1979).

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 that

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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 CFR §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 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 CFR §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 CFR § 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 related organization principles of 42 CFR § 413.17, CMS stated that consideration must be given to whether the composition of the new board of directors, <u>or other governing body and/or management team</u> 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, <u>inter alia</u>, certain relationships formed as a result of the consolidation of two entities constituted a related party transaction

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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.

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 CFR § 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 CFR § 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 CFR §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

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

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 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

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[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).

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

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 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.

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

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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.

This policy of not recognizing a gain or loss when the transaction is between related parties, whether it constitutes a reorganization or 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.[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 or mergers 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 or merger, where the predecessor corporation board continues significant control in the new corporation board, is treated the same as a reorganization for Medicare reimbursement purposes and no gain or loss is recognized. However, for example, where the predecessor corporation board does not continue significant control in the new corporation board, a gain or loss will be recognized for Medicare reimbursement purposes.

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

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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.")

> 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]

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

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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)).

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.

E. Board Decision in light of controlling regulation and policy.

The Administrator notes that the Board made several findings regarding the interaction of the various regulations on 42 CFR §413.134(l).[34] The Board found that

[34] While not dispositive to this case, the Board concluded that the CMS policy on consolidation revaluations in the final rule published Feb 5, 1979 was a change from the proposed rule published in April 1, 1977. The final rule states that it does not differ in substance from the proposed rule (44 Fed Reg. 6913) and it was made effective on the date published, an act consistent with that statement. An immediate effective date for any substantive change would have required a good cause exception under the APA published in the final rule. The final rule also stresses that the policy that the rule clarifies on the revaluation of assets is longstanding Medicare policy and does not note any changes on consolidations as a result of comments. The change referenced from the proposed rule is that the final rule dedicates separate paragraphs to related and unrelated transactions involving consolidations, similar to that provided for statutory mergers. Thus, based on the foregoing, one could conclude that this

the final rule at 44 Fed. Reg. 6913 (1979) conclusively limits the application of the related party rule to the consolidating entities. Further, the Board found that the general rules on the disposal of assets and related parties were not controlling over the specific language of paragraph (l). While the general related party rules could be interpreted to require an examination of the relationship between the consolidating corporations and the new corporation, the Board found that interpretation could not be applied to the transactions involving consolidation under paragraph (l). Moreover, the Board found that the specific provisions of paragraph (l) precluded the application of the bona fide sale requirement of the disposal of assets provisions of paragraph (f). The Board found that there was no requirement that depreciable assets be disposed of through a bona fide sale and that such a requirement was contrary to the nature of consolidations.

However, the Administrator finds that, as the issue under appeal involves the recognition of depreciation losses on the transfers of assets from a consolidation between non-profit entities, he cannot limit his review to 42 CFR §413.134(l). Paragraph (l) was drafted specifically to address the revaluation of assets for proprietary corporations that consolidate, while paragraph (f) specifically addresses circumstances under which a gain or loss will be recognized. Paragraph (k) did not modify or limit the general related party rules at §413.17 and does not address or modify the criteria for the recognition of gains or losses at paragraph §413.134(f). Instead, the Secretary explicitly stated that this provision was being promulgated consistent with both the related party rules and the disposal of depreciable asset rules set forth at paragraph (f) and thus must be interpreted consistent with those provisions.[35]

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change was to clarify the proposed language, rather than to promulgate a substantive change from the proposed rule.

[35] 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

In addition, contrary to the Board's finding, the CMS policy of examining the relationship between the corporation that transfers the assets and the corporation that receives the assets, does not obviate the application of the gain and loss provisions in all transactions involving a consolidation. For example, the PM illustrates circumstances when there is a consolidation that results in the calculation of a gain or loss. The PM Example 2 explains that:

> Corporation A and B consolidate to form Corporation C. Corporation A and B were unrelated prior to the transaction, each being controlled by its respective Board of Directors of eight members each. After the consolidation, Corporation C's Board of Directors consists of seven individuals, all of whom were members of Corporation A's board. Because no significant change of control of assets of corporation A occurred, the transaction as between A and C is deemed to be one of related parties and no gain and loss on it will be recognized as a result of the transaction. However, because there has been a significant change of control of the assets of Corporation B, the transaction as between B and C is not one of the related parties. Therefore, with respect to the assets transferred from B to C, a gain or loss may be recognized (if the other criteria for recognizing a gain or loss, including the requirement of a bona fide sale are met.)

As set forth in the foregoing example, a rule that looks at the parties before and after the transaction does not make superfluous the gain or loss provisions whenever there is consolidation or merger. For example, only in circumstances where there is a continuity of control between the former owner of the assets and the new owner of the assets is the transfer recognized as between related parties and no gain or loss allowed.

II. Findings of Facts and Conclusions of Law.

A. Denial of Reimbursement due to consolidation between related parties.

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corporate stock is not a sale of the corporate assets, the provisions of paragraph (f) of 405.415 are not applicable to the seller after such a transaction."); 44 Fed. Reg. 6913 ("Only if the assets are transferred by means of a bona fide transaction between unrelated parties would revaluation be proper.")

In this case, the record shows that Harrisburg Hospital was a non-profit, acute care facility located in Harrisburg, Pennsylvania. Seidle Memorial Hospital was a non-profit skilled nursing facility that became part of Harrisburg Hospital. The Provider operated under a single license and was assigned a single Medicare provider number. The Provider was a subaffiliate of, and controlled by, Capital Health System, which in turn was controlled by Capital Foundation.[36] By an Agreement and Plan of Consolidation (Agreement), dated September 4, 1994, Capital Health System, the parent corporation of the Providers(Harrisburg Hospital and Seidel Memorial Hospital) and the Polyclinic Health System, the parent corporation[37] of Polyclinic Medical Center (Polyclinic), agreed to consolidate to form New Co Health System.[38] A First Amendment to the Agreement and Plan of Consolidation, dated September 30, 1995, was entered into between Capital Health System and the Polyclinic Health System, which specified that the corporation formed as a result of the consolidation shall be named Harrisburg Polyclinic Health System (later changed to Pinnacle Health Hospitals (Pinnacle Hospitals)) and also specified that the necessary investigations were completed to allow a closing date of the transaction contemplated by the agreement effective December 31, 1995.[39]

Similarly, an Agreement and Plan of Consolidation was made between the Provider and Polyclinic Medical Center, as respective affiliates of Capital Health System and Polyclinic Health System, by which these affiliates would consolidate with and into Harrisburg Polyclinic Medical Center (later renamed Pinnacle Health Hospitals).[40] At the effective time, the separate existence of the consolidating corporations would cease and the successor corporation would succeed to all the properties, rights, privileges, powers and franchises of each and be subject to all the debts, liabilities, and obligations of each consolidating corporation. Pursuant to the terms of the consolidation, Pinnacle Hospitals acquired the Provider's total assets and assumed all of their liabilities. As a result, the Provider submitted a terminating Medicare cost report in which they claimed a loss on the disposal of their depreciable assets. The

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[36] For purposes of this review, Capital Health System Services may be referred to as the parent of the Provider. Capital Health System Services operated as a non-stock, non-profit corporation. Capital Area Health Foundation (Capital Foundation) operated as a non-stock, non-profit corporation. The stipulations indicate that Capital Foundations Board was the member of, and hence controlled, Capital Health System Services whose board in turn was the member of, and hence controlled, Harrisburg Hospital whose board in turn was the member of, and hence controlled, Seidle Memorial.

[37] Polyclinic Health System operated as a non-stock, non-profit corporation.

[38] Exhibit P-12.

[39] Exhibit P-15.

[40] Exhibit P-16.

loss was represented by the difference between the net book value of the assets they transferred to Pinnacle Hospitals and the liabilities which Pinnacle Hospitals had assumed. The Intermediary disallowed the claimed loss on depreciable assets.

With respect to the events leading up to the consolidation, the record shows that in early 1994, Capital Health determined that it would be prudent to create an integrated health care system through the consolidation of the assets and functions of their acute care hospital facilities. The record shows that Capital Health was in discussions with various health care facilities and considering the options of merging or consolidating.[41] As a result of the consolidation, good title to all of the assets of Harrisburg Hospital/Seidle Memorial Hospital, and Polyclinic Medical Center passed by operation of law to Harrisburg Polyclinic Medical Center (renamed Pinnacle Health Hospitals).

The record shows that Articles of Consolidation and Articles of Amendment were filed with the Pennsylvania Department of State for the consolidated controlling corporation and consolidated hospital corporation (Harrisburg Polyclinic Medical Center renamed Pinnacle Health Hospitals).[42] By operation of Pennsylvania law, each of the consolidating entities, including the Provider, ceased to exist. Pinnacle Health Hospitals became responsible for all of the liabilities of Harrisburg Hospital/ Seidle Memorial Hospital, and Polyclinic Medical Center, including those which were actual liabilities and reflected on their pre-consolidation financial records, and those liabilities which were contingent or unknown, and which were not reflected on those financial records. The record shows that a number of the board members of the two parent organizations and hospital corporations were appointed to the newly created corporations.[43] In addition, Capital Foundation and Polyclinic Foundation consolidated to create a new Foundation.

The record shows that the Provider included a claim for $8,971,274 on the Medicare cost report for the loss incurred as a result of the consolidation.[44] The loss claimed represented the difference between the assets acquired and the liabilities assumed by Pinnacle Health Hospitals. Upon audit of the Provider's cost report for the cost year ending December 31, 1995, the Intermediary disallowed the claim for reimbursement for the loss on consolidation incurred by the Provider.

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[41] *See,* e.g., Provider Position Paper, Exhibits P-5 – P-8. *See* Transcript Oral Hearing (Tr.) at 179, stating that Capital representatives met with Holy Spirit, Hershey Medical Center, and with Polyclinic Medical Center.

[42] *See,* e.g., Provider Exhibit P-61. The Articles of Amendment were dated April 3, 1996.

[43] *See,* e.g., Provider Exhibit P-134, Exhibit 1.

[44] *See,* e.g., Intermediary's Position Paper at 5.

The Administrator finds that the Board improperly determined that the consolidation was not a related party transaction. The Administrator disagrees with the Board's reasoning that, in determining whether the transaction in this case occurred between related parties, it was not necessary to examine relationships established after the consolidating transaction. Instead, for purposes of determining whether parties are related, an examination of relationships of the entities both before and after the transaction is appropriate. In applying the related organizations principle at 42 CFR § 413.17, PM A-00-76, explained that:

> [I]t is appropriate to compare the governing board/management team composition before the transaction with the governing board/management team composition after the transaction, even though there was no contemporaneous co-existence of the those boards/teams.

Furthermore, when evaluating relatedness, PM A-00-76 stated that the focus of the inquiry should be "whether significant ownership or control exists between a corporation that transfers assets and the corporation that receives them."[45] Thus, when determining whether a merger or consolidation involving a non-profit provider is a "related party" transaction, the Administrator finds that CMS' analysis is not limited to the relationship between the parties before the transaction, but also includes an analysis of the relationship following the transaction.

Notably, the Hospital's Agreement and Plan of Consolidation, Bylaws, Article III, provided for the creation of the Interim and Permanent Board of Directors of the Corporation.[46] The Board of Directors of the newly formed entity was to consist of the following: "22 individuals, composed of the System CEO, the Corporation CEO, eight members elected from the current Board of Directors of Polyclinic Health System (or Polyclinic Medical Center), eight members elected from the current Board of Directors of Capital Health System Services (or Harrisburg Hospital or Seidle Memorial Hospital), and four ex officio members…"[47]

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[45] PM A-00-76 lists considerations in evaluating control including: (1) the determination of common control is subjective, i.e. no rule of thumb; (2) each situation must be examined on its own facts and merits; (3) a finding of common control does not require 50 percent or more representation; and (4) control need not be actually exercised, the mere potential to control is sufficient.

[46] *See,* e.g., Provider Position Paper, Exhibit P-16, Bylaws of Harrisburg Polyclinic Medical Center. Article III Section 3.02(a) provided for the Interim Board to automatically become the permanent Board of Directors of the Corporation after the expiration of the Interim Period.

[47] *Id.*

The record shows that three out of a total of seven individuals from the Harrisburg/ Seidle governing board became Board members of Pinnacle Health Hospitals.[48] A fourth board member, Mr. Martin Murray, became a member of the Pinnacle Health System board after the consolidation.[49] Mr. Murray's testimony alleged that only four additional individuals from the governing board of Capital Area Health Foundation also became members of the governing board of Pinnacle Health System.[50] However, the witness failed to mention that six members, from the governing board of Capital Health System, also became members of the Pinnacle Health Hospitals.[51] Thus, the record shows that a significant number of the board members of Pinnacle Health Hospitals and Pinnacle Health System were from the Provider and its controlling corporation's governing boards. The Provider and Capital Health System retained and continued to have significant control of its asset, as exemplified by its board membership in the respective consolidated hospital and the related Pinnacle Health System. The nine members from Capital Health System, Harrisburg Hospital/ Seidle Memorial Hospital composed nearly 41 percent of Pinnacle Health Hospital Board. Moreover, the record shows two additional members, Carl Bronitsky and Pam Iams (ex officio Auxillary), as being "Former Capital Health System Board Members" bringing this number to 11 out of 22 board members, or 50 percent.[52]

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[48] *See,* e.g., Tr. at pp. 187-191.

[49] *Id.*

[50] The total number of carry-overs to the Pinnacle Health Systems Board from the Provider and/or Capital Health System, was six (two individuals who served on both the Provider's Board, and the Capital Health System Board, and four additional individuals from the Capital Health System Board). Mr. Murray testified to four additional individuals from the Capital Health Foundation Board, a related controlling party, who became members of the Pinnacle Health System Board.

[51] The record is not developed as to the continuation of the Provider's and its controlling party affiliates' senior management in the consolidated entities, although it was apparent, for example, that the Provider's legal counsel continued in his same role in the new entity.

[52] Provider's Position Paper, Exhibit P-105, Pinnacle Health System, Minutes of the Meeting of Board of Directors (Jan. 16, 1996).

Pursuant to Pinnacle's Bylaw, the record shows that six out of 12, exactly 50 percent of the members of Pinnacle Health System, controlling organization came form the Provider's/controlling related corporations board of directors. The record also shows that six out of 12, exactly 50 percent, of the members of Pinnacle Health System, the controlling organization, came from the provider's/controlling affiliate's board of directors.[53] The fact that 50 percent of the post-consolidation Pinnacle Health System board members were individuals from the board of the Provider and their controlling affiliate boards is additional evidence that there is continuity of control after the consolidation which again is sufficient to show them as related parties.[54]

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[53] *Id.*

[54] The chart herein sets out the membership of the Provider and Capital Health Systems governing Boards, alongside the consolidated entity Pinnacle Health Hospitals, and its related controlling organization, Pinnacle Health System. Information on the individuals on the respective pre and post-consolidation "Foundation" boards was not readily ascertained.

Harrisburg Hospital –Seidle Memorial Hospital	Capital Health System	Pinnacle Health Hospitals	Pinnacle Health System
Cramer, John S. Edwards, Susan *Gutierrez, Felix, MD* ***Murray, Martin L.*** ***Snelbaker, Richard v.*** Ulrich, Richard, MD Weigel, Jesse, MD KEY: *Italicized: Director from Harrisburg Hospital – Seidle Memorial Hospital* ***Italicized(Bold): Director from Harisburg Hospital – Seidle Memorial Hospital AND Board Member of Capital Health System*** **Bold – Board Member of Capital Health System**	**Adair, James** **Berry, J. Douglass** ***Cramer, John S.*** Criss, Kathy **Duggan, Francis Jr. MD** **Fowler, Robert D.** Graham, Susan A. **Grass, Alex** **Leech, Robert E.** Maliniak, Keith, MD **McInnes, Harold A.** ***Murray, Martin L.*** Smither, A. John ***Snelbaker, Richard, Esq.*** **Spector, Morton** Taylor, James I. **Waters, Nathan H., Esq.**	**Berry, J. Douglass** Brenner, Herbert J. Bronitsky, Carl, MD** Burdge, Jeffrey J. ***Cramer, John S.*** Crispen, Susan Folk, Robert H. **Fowler, Robert D.** Franklin, Stephen H. *Gutierrez, Felix, MD* Hathaway, Derek C. Iams, Pamela** Jennings, Christopher R. **Leech, Robert E.** **McInnes, Harold A.** Rosen, Norman Rudy, Frank R., MD ***Snelbaker, Richard, Esq.*** **Spector, Morton** Stabler, Donald B. **Walters, Nathan H. Jr.*** Wengert, Paul A. Jr., MD	**Adair, James** ***Cramer, John S.*** Crispen, James F. MD **Duggan, Francis Jr. MD** Franklin, Stephen H. **Grass, Alex** Hughes, Carlton E. King, Willian J. Marley, James E. **McInnes, Harold A.** ***Murray, Martin L.*** Nation, Robert F.
<u>Conclusion:</u> ***** Possible Misspelling ** Provider Exhibit P-99 lists these two individuals as "Former CHS Board Members"	**15 total carry-overs from Providers and/or Capital Health System, plus those serving on the Foundation.** ***** Possible Misspelling	**11 out of 22 directors from the Providers and/or Capital Health System.**	**6 out of 12 board members from the Providers and/or Capital Health System.**

In addition, there was a continuity of business enterprise and purpose between the Provider/controlling affiliate corporation and the consolidated hospital/controlling affiliate corporations. The Bylaws of consolidated hospital entity, Pinnacle Health Hospitals (formerly Harrisburg Polyclinic Medical Center), showed that the new hospital was created for a charitable mission to, "establish, maintain, and operate health care programs and facilities for the diagnosis, treatment and betterment of individuals with actual or potential health problems.…"[55] The record shows that the Bylaws of the Provider show the same exact purpose of the resulting entity, as the Provider was created to "establish, maintain, and operate health care programs and facilities for the diagnosis, treatment, and betterment of individuals with actual or potential health problems.…"[56] Thus, the stated purpose and mission of the Provider and the consolidated entity, Pinnacle Health Hospitals, was identical.

This continuity of business enterprise is also evident in the Agreement and Plan of Consolidation between Capital Health System and Polyclinic Health System. The Agreement memorializes that:

> Whereas, CHSS [Capital Health System] and PHS [Pinnacle Health System] have concluded from such studies that the mutual charitable and education purposes of their organization to meet the existing and projected health care needs of their community can be served in the most efficient and cost-effective manner through the combination of their respective multi-corporate systems into a single health care delivery system pursuant to the terms of this Agreement; and
>
> Whereas, the objectives of such combination will coincide with the charitable purposes of each party, namely organizing, financing and providing high quality, cost-effective health services and medical education and clinical research through the efficient operation of a comprehensive continuum of care to Central Pennsylvania; and
>
> Whereas, it is anticipated that, by combining their respective resources the parties will be better able (a) to meet the health needs of the under-

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See Providers' Exhibits P-92 (Capital Health System, Minutes of Board of Directors, dated Dec. 14, 1994); P-105 (Pinnacle Health System Minutes of the Board of Directors, dated Jan. 16, 1996); Parties Stipulation, dated May 15, 2007, Testimony of Mr. Murray at Tr. 187-191.

[55] *See*, e.g., Provider Position Paper, Exhibit P-104, Bylaws of Harrisburg Polyclinic Medical Center, Article I, Section 1.02.

[56] *See*, e.g., Provider Position Paper, Exhibit P-96, Bylaws of Harrisburg Hospital, Article I, Section 2.

> served through improved access and (b) to benefit the entire community through the development of new products, the elimination of duplicated services, and the provision of a full continuum of care to the community through components of the combined organization and/or formal relationships with other providers.[57]

Thus, the business enterprise of the new hospital and parent corporations were identical with that expressed by the constituent hospital and parent corporations, while the agreement to consolidate shows an express purpose to continue that same enterprise in a more effective way through the combination of the organizations. The agreement shows the continuity of the enterprise and purpose between the consolidating entities and the post-consolidated hospital/parent organizations and the intent to combine their resources to better accomplish that mission.

Although not binding under the Medicare rules, the record also shows an IRS letter issued pursuant to the involved entities' request. The letter shows both the Provider's understanding of the events surrounding this transaction and the IRS analysis of those events. The letter stated that:

> P [New Co Health System – Pinnacle Health System] is a non-profit corporation to be formed upon the consolidation of Q [New Foundation – formerly, Polyclinic Medical Center Foundation] and R [Capital Health System Services]. As a consolidated entity, P will succeed to the assets and functions of its constituent organizations. P will be organized under the non-profit corporation law of S [Pennsylvania] as a non-membership corporation with a self-perpetuating board to be made up initially 50% of former Q board members and 50% of former R board members.[58]

Again, reflecting the intent and understanding of the Provider at the time of the consolidation, the letter stated that:

> In order to meet the perceived needs of the communities they serve both Q [New Foundation – formerly, Polyclinic Medical Center Foundation] and R [Capital Health System Services] came to the independent conclusion that they must move to expand services alternatives to traditional inpatient hospitals, while at the same time reducing the costs inherent in providing those traditional inpatient

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[57] *See*, e.g., Provider Exhibits P-12.

[58] *See*, e.g., Provider Position Paper, Exhibit P-62. IRS letter dated September 28, 1995.

> hospitalization services.…You have stated that Q and R recognized that the elimination of duplicative and underutilized services would be best accomplished by a merger with another provider offering similar products and having similar mission and objectives. After holding discussions with other hospitals in the area, each party hospital determined that the other best met the criteria for a merger partner. This was based primarily on the similarities and outlooks between the two organizations, both of which are non-profit, allopathic and community-based….
>
> You have requested the following rulings in transactions:
>
> ….
>
> 3) The proposed transfer of assets and liabilities of assets pursuant to the consolidation and related subaffliations will not result in the recognition of any gain or loss under section 511 through 514 of the code by the transferor or transferee in any transaction described above,
>
> 4) To the extent that funds, assets, services, or personnel are transferred between or among organizations pursuant to the consolidation and related subaffiliations will not result in the recognition of any gain or loss under section 511 through 514 of the code.
>
> ….
>
> Accordingly based on all the facts and conclusion described above, we rule as follows:
>
> ….
>
> 3) The proposed transfer of assets and liabilities pursuant to the consolidation and related subaffiliations will not result in the recognition of any gain or loss under section 511 through 514 of the code.
>
> 4) To the extent that funds, assets, services, or personnel are transferred between or among organizations pursuant to the consolidation and related subaffiliations will not result in the recognition of any gain or loss under section 511 through 514 of the code. [59]

Consistent with the referenced documents, the IRS letter shows that, in entering into the consolidation, the Provider intended to continue serving the communities' health care needs, but in a more effective combined form. The Administrator finds, after reviewing the totality of evidence, that no loss can be recognized under Medicare rules, because there was a continuity of control between the Provider/parent and the post-consolidation entities.

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[59] *Id.*

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

The Board criticized the examination of IRS principles applicable to statutory reorganizations citing that the Administrator in *Cushing* had not explained the characteristics that converted a consolidation, executed strictly under State law, into a mere reorganization. Instead, the Board concluded that all mergers and consolidations are to some extent reorganizations and that the Agency decided to limit the related party rule to the constituent hospitals, which was binding in this case.

The Administrator finds that, as noted above, the common criteria between IRS rules and Medicare rules is that a transaction is treated similar to, or as, a reorganization (in that no gain or loss is recognized), regardless of the transaction title, when there is a continuity of interest or control between the constituent corporations and the new corporation. That is, evidence of a continuity of interest or control, is evidence that the entities have "recast" their interests in another form and no actual loss has been incurred. Reasonable cost rules must be interpreted consistent with this economic reality.

B. Denial of Reimbursement due to lack of bona fide sale.

The Administrator finds that the disposal of asset rules under 42 CFR§405.134(f) are properly applied in the event of a consolidation. This means that, in order for a loss to be recognized, a transaction resulting in the transfer of depreciable assets must meet one of the applicable criteria of paragraph (f).

Applying the rules to the facts of this case, the Administrator finds that the Provider's transfer of the assets to Pinnacle Health Hospitals did not constitute a bona fide sale. There is no evidence in the record of arm's length bargaining, nor an attempt to maximize any sale price as would be expected in an arms' length transaction. Further, the consideration, or lack thereof, received for the depreciable assets supports a finding that the transaction did not constitute a bona fide sale. Section §104.24 of the PRM states:

> A bona fide sale contemplates and arms 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 set interest."

In this case, the record shows that the Provider is a related party in this consolidation as demonstrated by the continuity of control it maintained. Therefore, the transaction was not a *bona fide* sale, and the Intermediary's disallowance of the loss is upheld. Furthermore, the Administrator also finds that the consideration (assumption of liabilities) received for the depreciable assets supports a finding that the transaction did not constitute 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 fair market value (FMV) of the assets is a required aspect of the analysis. The record shows that the Provider's total assets were valued at $154,580,565, which included current and monetary assets valued at $104,538,413, and depreciable assets valued at $50,042,152. Pinnacle Health Hospitals assumed the Provider's liabilities in the amount of $92,669,532. This means that the value of the Provider's current and monetary assets alone exceeded the liabilities assumed by $11,868,881.[60] No additional consideration was transferred by Pinnacle Health Hospitals. As a practical matter, if one assumes a dollar to dollar valuation of the current and monetary assets, no consideration was transferred for the depreciable and other assets.

The record shows that the Provider's current assets exceeded its liabilities; so in essence, the Provider donated its depreciable assets to Pinnacle Health Hospitals.[61] Furthermore, since the facts do not support a finding that the Provider received reasonable consideration, the transaction was not a *bona fide* sale. As set forth in the PRM at §104.24, reasonable consideration is a required element of a *bona fide* sale. As stated above, a *bona fide* sale contemplates an arm's length transaction between unrelated parties for reasonable consideration.

Also evidence that there was no arm's length negotiation is that the appraisal, dated September 8, 1997,[62] was conducted well after the consolidation had been entered

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[60] It is not clear whether the current and monetary assets also would include the almost nine million dollar loss claimed on this case.

[61] *See*, e.g., Intermediary's Position Paper, Exhibit I-13.

[62] *See*, e.g., Provider's Position Paper, Exhibit P-106.

into on September 4, 1994.[63] That is, the Provider's valuation of its assets, through an appraisal, was not done in order to ascertain the value of its assets prior to entering negotiations for the consolidation. Instead, documents in the record show that other factors were more important in finding a consolidation partner, such as potential candidates' reputation, cost position, product line strength, financial health, cultural/personality compatibility, strategic considerations, political considerations, board makeup, all weighted in order to ensure the continuity of the Provider's charitable mission in providing health care to members of its community.[64]

As a loss cannot be allowed in this case, the Administrator does not reach the issue of how to calculate the loss, in reference to the medical records and assembled workforce. 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 and monetary assets 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.[65]

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[63] As the liabilities were less than the current and monetary assets, the issue of whether reasonable compensation was received in light of the "fair market value", based on an appraisal, as opposed to the net book value, is moot. The economic reality means that, as a practical matter, the depreciable assets were, in effect, transferred for no consideration, if one assumes a dollar to dollar value for the current and monetary assets, in allocating the sale price. Under this analysis, the transfer of depreciable assets was in effect a donation, under 42 CFR 413.134(b)(8) and will not result in the recognition of a gain or loss.

[64] *See*, e.g., Exhibit P-6, P-7, P-8.

[65] The Administrator hereby incorporates by reference the Administrator's decision in PolyClinic Medical Center, PRRB Dec. No. 2008-D38.

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: **11/21/08** **/s/**

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