CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Germantown Hospital and Medical Center **Provider** **vs.** **Mutual of Omaha Insurance Company** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 08/31/97** **Review of:** **PRRB Dec. No. 2004-D36** **Dated: September 1, 2004**

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

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's denial of the Provider's loss on disposal of assets was proper.

The Board reversed the Intermediary's decision and found that the Provider was entitled to claim a loss on the disposal of depreciable assets stemming from the

Provider's (Germantown Hospital and Medical Center[1]) merger with Germantown Hospital and Community Health Services (hereafter referred to as New Germantown). The Board found that there was no evidence to support the Intermediary's argument that common ownership existed between the parties prior to the merger or that any level of control existed between them at that time.

The Board disagreed with the Intermediary's assertion that "continuity of control" makes the merger a related party transaction. The Board disagreed with the Intermediary's application of the related party principle. The Board stated that the plain language of 42 C.F.R. § 413.134(1)(2)(i) bars application of the related party principle to the merging parties' relationship after the merger. In any case, the Board was not persuaded by the Intermediary's "continuity of control" argument that the Provider controlled the post-merger entity because some of its pre-merger directors were on the surviving entity's board and some of its pre-merger managers continued to be employed by the surviving entity. The Board found that the power of the surviving entity's board were severely limited.

The Board also disagreed with the Intermediary that the merger was not a *bona fide* transaction pursuant to 42 C.F.R. § 413.134(f)(2). The Board found that actions taken by the Provider were consistent with the concept of arm's length, *bona fide* negotiations.

In response to the Intermediary's alternative argument that the Provider's claimed amount of Medicare reimbursement was incorrect, the Board found the following: the average utilization rate should not be used to determine Medicare's share of the loss; the $6 million commitment made by Albert Einstein Healthcare Network (Einstein) to community access should not be included as consideration in the loss calculation; the endowment funds should not be represented as an asset in the loss calculation but the present day value of their income should be included as an asset; and the value of the Provider's medical library and related materials should be reflected as an asset in the loss calculation while the value of the medical records, radiology film and assembled workforce should be excluded from the loss calculation.

SUMMARY OF COMMENTS

CMM requested reversal of the Board's decision. CMM argued that the Board incorrectly held that the Provider was entitled to claim capital reimbursement as a result of "loss" upon merger. CMM claimed that the Provider was not engaged in arm's length bargaining. The Provider did not attempt to negotiate the best price

[1] Intermediary's Exhibit I-2 at 1.

for its assets, nor did it seek additional compensation for the excess value of its assets over its liabilities. CMM stated that Medicare does not reimburse providers for artificial losses generated through a provider's furtherance of a non-economic agenda. Rather, Medicare reimburses for actual losses that result from arms length bargaining. CMM claimed that the Provider did not receive reasonable consideration for its assets noting that there was a significant discrepancy between the worth of the Provider's assets and the consideration it received for them. CMM also claimed that the Provider failed to show that it transferred its depreciable assets to an unrelated party noting that the Provider had a significant affiliation with New Germantown and Einstein prior to the merger. In addition, subsequent to the merger, the Provider continued to influence the decisions affecting assets through its board representation and the continuity of it senior management.

The Intermediary requested reversal of the Board's decision. The Intermediary argued that the merger did not result in a *bona fide* transaction and was between related parties. The Intermediary claimed that the transaction that occurred was to ensure maximum depreciation capture. In the alternative, the Intermediary argued that even if the Board concludes that the loss was allowable, the Provider's claimed amount of Medicare reimbursement was incorrect. The Intermediary claimed that the Provider did not document the Medicare utilization rate percentage used to determine Medicare's share of the loss, and therefore, the Provider did not meet its burden for proper determination of costs payable under the program. The Intermediary disagreed with the Board that the $6 million Einstein agreed to commit to New Germantown for community access should not be included in the consideration used to compute the Provider's loss.

The Intermediary stated that should the Provider prevail, the contingent consideration of $6 million should be included as consideration in the merger based on general accepted accounting principles (GAAP) and the fact that the Provider and the new entity entered into an agreement prior to the merger and the consideration (or lack of) was an impelling influence that induced the Provider into the transaction. The Intermediary also argued that contrary to the Board's decision, endowments are identified as assets under GAAP and should be included in the Provider's loss calculation, but the medical library is not an asset under GAAP and should not receive an allocation of consideration should the Provider prevail.

The Provider commented requesting that the Administrator affirm the Board's decision, with modification to the Board's decision as to the calculation of the loss. The Provider argued that the Board was correct in its determinations that the Provider was entitled to claim a loss on the disposal of depreciable assets

stemming from its merger with New Germantown. However, the Provider disagreed with the Board with respect to: the Board's assumption that the Provider calculated its loss only using average utilization rates for each year from 1981; the Board's reliance on GAAP, as opposed to Medicare regulation, for its conclusion that the endowments should not be included in the loss calculation; the Board's holding that the value of the medical records, radiology films and assembled workforce should not be included in the calculation of the Provider's loss as intangible assets.

The Provider also claimed that the parties were not related by common ownership or control prior to the merger. The Provider stated that 42 C.F.R. § 413.134(l)(2)(i) (1996) bars application of the related party principle to the merged parties' relationship after the merger. In any case, there was no continuity of control, and the transaction was an arm's length, *bona fide* transaction.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

I. Medicare Law and Policy -- Reasonable Costs.

Section 1861(v)(1)(A) of the Social Security Act establishes that Medicare pays for the reasonable cost of furnishing covered services to program beneficiaries, subject to certain limitations. This section of the Act also defines reasonable cost as "the cost actually incurred, excluding there from any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The Act further authorizes the Secretary to promulgate regulations establishing the methods to be used and the items to be included in determining such costs. Consistent with the statute, the regulation at 42 CFR §413.9 states that all payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries.

A. Capital Related Costs.

Reasonable costs include capital-related costs. Consistent with the Secretary's rulemaking authority, the Secretary promulgated 42 CFR §413.130, which lists

capital-related costs that are reimbursable under Medicare. Capital-related costs under Medicare include depreciation, interest, taxes, insurance, and similar expenses (defined further in 42 CFR §413.130) for plant and fixed equipment, and for movable equipment.

Title VI of the Social Security Amendments of 1983[2] added §1886(d) to the Act and established the prospective payment system (PPS) for reimbursement of inpatient hospital services provided to Medicare beneficiaries. Under this system, hospitals are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge according to a list of diagnosis-related groups. Reimbursement under the prospective payment rate is limited to inpatient operating costs. The Social Security Amendments of 1983[3] amended subsection (a)(4) of §1886 of the Act to add a last sentence, which specifies that the term "operating costs of inpatient hospital services", does not include "capital-related costs (as defined by the Secretary for periods before October 1, 1986)... ." That provision was subsequently amended until finally, §4006(b) of OBRA 1987 revised §1886(g)(1) of the Act to require the Secretary to establish a prospective payment system for the capital-related costs of PPS hospitals for cost reporting periods beginning in fiscal year (FY) 1992.

1. Depreciation.

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

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

[2] Pub. Law 98-21.

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

> disposition, reimbursement for depreciation must be adjusted so that Medicare pays the actual cost the provider incurred in using the asset for patient care.[4]

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

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

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

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

The regulation specifies that only certain events will result in the recognition of a gain or loss in the disposal of depreciable assets. The Secretary explained in proposed amendments to the regulation clarifying and expanding existing policy on the recognition of gains and losses, in 1976, that:

> The revision would describe the various types of disposal recognized under the Medicare program, and would provide for the proper

[4] 44 Fed. Reg. 3980 (Jan 19, 1979).

> computation and treatment of gains and losses in determining reasonable costs. [5]

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. [6] (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 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.)

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[5] 41 Fed. Reg. 35197 (August 20,1976) "Principles of Reimbursement for Provider Costs: Depreciation: Allowance for the Depreciation Based on Asset Costs." (Proposed rule.)

[6] 44 Fed. Reg. 3980. (1979) "Principles of Reimbursement for Provider Costs."(Final rule.)

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

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

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

> A *bona fide* sale contemplates an arm's length transaction between a willing and well-informed buyer and seller, neither being under coercion, for reasonable consideration. An arm's length transaction is … negotiated by unrelated parties, each acting in its own self interest. [7]

Paragraph (f)(3) addresses gains or losses realized from sales within 1 year after the provider terminates from the program, while §413.134(f)(4) addresses exchange trade-in or donation[8] of the asset stating that: "[g]ains or losses realized from the exchange, trade-in, or donation of depreciable assets are not included in the determination of allowable cost." Finally, paragraph (f)(5) explains that the treatment of gains and losses when there has been an abandonment (permanent retirement) of the asset, and paragraph (f)(6) explains the treatment when there has been an involuntary conversion, such as condemnation, fire, theft or other casualty.

2. Revaluation of Assets.

Historically, as reflected in the regulation, the disposal of a depreciable asset used to render patient care may result in two separate and distinct reimbursement

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

[8] A donation is defined in §413.134((b)(8). An asset is considered donated when the provider acquires the assets without making payment in the form of cash, new debt, assumed debt, property or services. Section 4502.12 of the Intermediary Manual states that when a provider is donated as an ongoing facility to an unrelated party, there is no gain/loss allowed to the donor. The valuation of the assets to the donor depends upon use of the assets prior to the donation.

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

This latter issue, on the revaluation of assets, was the subject of significant litigation for the Medicare program regarding complex transaction and resulted in agency rulemaking on the subject. In response to litigation, the regulations at 42 CFR §413.134(k) and (l)[10] 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:

> (k) *Transactions involving a provider's capital stock*—
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> (l)(2) *Statutory merger*. A statutory merger is a combination of two or more corporations under the corporation laws of the State, with one of the corporations surviving. The surviving corporation acquires the assets and liabilities of the merged corporation(s) by operation of State law. The effect of a statutory merger upon Medicare reimbursement is as follows:
> (i) *Statutory merger between unrelated parties*. If the statutory merger is between two or more corporations that are unrelated (as specified in §413.17), the assets of the merged corporation(s) acquired by the surviving corporation may be revalued in accordance with paragraph (g) of this section. If the merged corporation was a provider before the merger, then it is subject to the provisions of paragraphs (d)(3) and (f) of this section concerning recovery of accelerated depreciation and the realization of gains and losses. The basis of the assets owned by the surviving corporation are unaffected by the transaction. An example of this type of transaction is one in which Corporation A, a nonprovider, and Corporation B, the provider, are combined by a statutory merger, with Corporation A being the surviving corporation. In

[9] 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.

[10] (2002) Originally codified at 42 CFR §405.415(l).

> such a case the assets of Corporation B acquired by Corporation A may be revalued in accordance with paragraph (g) of this section.
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> (ii) *Statutory merger between related parties*. If the statutory merger is between two or more related corporations (as specified in §413.17), no revaluation of assets is permitted for those assets acquired by the surviving corporation. An example of this type of transaction is one in which Corporation A purchase the capital stock of Corporation B, the provider. Immediately after the acquisition of the capital stock of Corporation B, there is a statutory merger of Corporation B and Corporation A, with Corporation A being the surviving corporation. Under these circumstances, at the time of the merger the transaction is one between related parties and is not a basis for revaluation of the provider's assets.

However, paragraph (l) is silent with respect to the determination of a gain or loss for corporations that consolidate.

B. Related Organizations

Finally, 42 CFR § 413.134(l)(2)(i) and (ii) references the related organization rules at 42 CFR§ 413.17. The regulations 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.
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> (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.
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> (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 or PRM, which provides guidelines and policies to implement Medicare regulations for determining the reasonable cost of provider services. In determining whether the parties to a transaction are related, the PRM at §1004 et. seq., establishes that the tests of common ownership and

control are to be applied separately, based on the facts and circumstances in each case. With respect to common ownership, the PRM at §1004.1 states:

> This rule applies whether the provider organization or supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or nonprofit. In the case of nonprofit organization, ownership or equity interest will be determined by reference to the interest in the assets of the organization (e.g., a reversionary interest provided for in the articles of incorporation of a nonprofit corporation).[11]

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

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

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 then to provide goods and services for a profit, and may obtain significant resources from donors who do not expect to receive monetary repayment of or return on the resources they provide. These differences, among others, cause non-profit organizations to associate or affiliate through mergers or consolidations for reasons that may differ from the traditional for-profit merger or consolidations. In contrast, the regulations at 42 CFR 413.134(l) were written to address only for-profit mergers and consolidations.

The PM also noted that, unlike for-profit mergers or consolidations, which often involve a dispatching of the former governing body and/or management team, many non-profit mergers and consolidations involve the continuation, in whole or part, of the former governing board and/or management team. Thus, in applying the related organization principles of 42 CFR 413.17, CMS stated that consideration must be given to whether the composition of the new board of directors, or other governing body and/or management team include significant representation from the previous board or management team. If that is the case, no real change of control of the assets has occurred and no gain and loss may be recognized. The fact that the parties are unrelated prior to the transaction does not prohibit a related organization finding. This PM recognized that, inter alia, certain relationships formed as a result of the merger or consolidation of two entities constituted a related party transaction for which a loss on the disposal of assets could not be recognized. The PM stressed that "between two or more corporations that are unrelated" should include the relationship between the constituent hospitals and the merging or consolidating entity.

Consequently, the PM A-00-76 states that:

> whether the constituent corporations in a merger or consolidation are or are not related is irrelevant; rather the focus of the inquiry is

> whether significant ownership or control exists between a corporation that transfers assets and the corporation that receives them.

The PM stated that the term "significant", as used in the PM has the same meaning as the term "significant" or "significantly", in the regulations at 42 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, the PM stated that many non-profit mergers and consolidations have only the interests of the community at large to drive the transaction. This community interest does not always involve engaging in a bona fide sale or seeking fair market value of assets given. Rather, the assets and liabilities are simply combined on the merger/consolidated entities books. The merged/consolidated entity may or may not record a gain or loss resulting from such a transaction for financial reporting purposes. However, notwithstanding the treatment of the transaction for financial accounting purposes, no gain or loss may be recognized for Medicare payment purposes unless the transfer of the assets resulted from a bona fide sale as required by the regulation at 413.134(l) and as defined in the PRM at section 104.24. The PM stated that the regulation at 42 CFR 413.134(l) does not permit a gain or loss resulting from the combining of multiple entities' assets and liabilities without regard to whether a bona fide sale occurred. The PM stressed that a bona fide sale requires an arm's length business transaction between a willing and well-informed buyer and seller. This also requires the analysis of the comparison of the sales price with the fair market value of the assets acquired, as reasonable consideration is a required element of a *bona fide* sale.

Notably, the Administrator finds that the requirement that the term "between related organizations" include an examination of the relationship before and after a transaction of assets under 42 CFR §413.17 (§405.17) was applied as early as 1977 by the agency in evaluating whether accelerated depreciation would be recaptured. The agency decided that "when the termination of the provider agreement results from a transaction between related organizations and the successor provider remains in the health insurance program and its asset bases are the same as those of the terminated providers, health insurances reimbursement is equitable to all parties": thus, the depreciation recovery

provisions would not be applied.[12] 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.[13] Thus, the PM interpretation of the related party rules as requiring an examination of the relationship before and after the transfer of assets is consistent with early Medicare policy and HCFAR 80-4.

This interpretation, that "between related organizations" must include an examination of all parties to the transaction, both before and after, is also consistent with the reality of a transaction involving the merger or consolidation of entities: the deal is initially between the merging or consolidating entities, but, as part of the merger or consolidation, they will cease to exist effective with the merger or consolidation. In contrast, the transfer of the assets is between the merging or consolidating entities and the newly created corporation. Thus, the parties to the transaction involve the merger or consolidation corporations and the newly created corporation. Hence, Medicare reasonably examines the relationship between the merging or consolidating corporations (transferor) and the newly created corporation and recipient of the Medicare depreciable assets (transferee) to determine whether the transfer involved a related party transaction.

Finally, this interpretation set forth in the PM is not inconsistent with the language of 42 CFR 413.134(l)(2)(ii) that refers to "between two or more corporations that are related" with respect to proprietary corporations. CMS has always recognized a merger or consolidation as a transaction wherein two or more corporations combine to create a new corporation. Therefore, CMS reasonably applies the related parties rules in requiring an examination of the relationships of the merging or consolidating corporations and the newly created corporation.

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

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[12] 42 Fed. Reg. 45897 (1977).

[13] 42 Fed. Reg. 45897, 45898 (September 15, 1977) (Recovery of excess cost resulting from the use of accelerated depreciation when termination of provider agreement results from transaction between related organizations.)

the Medicare program, has developed specific policies on the reimbursement effect of various types of CHOW transactions, which may be different from treatment under GAAP.

Corporations are included as one of the possible types of provider organizations. Section 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. Notably, Medicare policy permits a revaluation of assets acquired in a statutory merger between unrelated parties, when the surviving corporation is a provider. Therefore, the surviving corporation must be a provider or a related organization to the provider, in order for there to be a revaluation of assets. The merger of a nonprovider corporation into a provider corporation is not a change in ownership for the provider corporation, and does not result in the revaluation of assets of the provider corporation. Notably, Medicare policy at § 4502.10 does not permit a revaluation of assets affected by a "reorganization" of a corporate structure. All such transactions are considered among or between related parties. As an example the Intermediary Manual explains that:

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

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

Section 4508.11 of the Intermediary Manual,[14] in addressing stock corporations. Medicare program policy places reliance on GAAP, as expressed in Accounting

[14] Section 4504.1 states that: "where Medicare instructions are silent as to the valuation of consideration given in an acquisition, rely upon generally accepted

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,[15] 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.[16]

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.

This policy of not recognizing a gain or loss when the transaction is between related parties, whether it constitutes a reorganization, merger or consolidation, is also consistent with Internal Revenue Service (IRS) rules on the non-recognition

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accounting principles. APB No. 16 discusses valuation methods of consideration given for assets acquired in business combinations."

[15] 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).

[16] While APB No. 16 and the pooling of interest provision was rescinded, leaving only the "purchase" method of accounting for business combinations, the CHOW does not reflect this change. Moreover, while FASB No. 141 did replace APB No. 16 effective June 2001, at the present, not-for-profit (NFP) organizations are excluded from the scope of FASB No. 141.

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.[17] 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.[18]

Under IRS rules, some mergers or consolidations are considered statutory reorganizations and subject to the non-recognition of a gain or loss. The terms reorganization, mergers 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.[19] For example, a consolidation where the predecessor corporation board continues significant control in the new corporation board is treated the same as a reorganization for Medicare reimbursement purposes and no gain or loss is recognized. However, for example, where the predecessor corporation board does not continue significant control in the new corporation board, a gain or loss will be recognized for Medicare reimbursement purposes.

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

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[17] See, e. g., Guernsey v. Shalala, 115 S. Ct. 1232 (1995), analogizing Medicare rules to IRS rules in citing to Thor Power Tools v. Commissioner, 439 U.S. 522 (1979).

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

[19] 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 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.[20] (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."[21] 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."[22]

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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[20] Commissioners of IRS v. Webster Estates, 131 F. 2d 426, 429 (2nd Cir.1942) citing Helvering v. Schoellkopf, 100 F. 2d 415 (2d Cir) While the foregoing IRS cases illustrate the continuity of interest, the Administrator notes that the Medicare program does not recognize a loss on sale as a result of a stock transfer regardless of the relationship between the parties. Case law also shows that term "continuity of interest" as provided in the IRS regulation is at times used interchangeably with the term "continuity of control." See e.g. New Jersey Mortgage and Title Co. v. Commissioner of the IRS, 3 T. C. 1277 (1944); Detroit–Michigan Stove Company v. U.S., 128 Ct. Cl. 585 (1954).

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

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

court in Unionbancal Corporation v. Commissioner, 305 F. 3d 976 (2001), explained that:

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

Consequently, one purpose of the IRS policy is to prevent the claiming of a gain or loss when no such event has in fact occurred. Similarly, the related party rules under Medicare, in holding that there is no recognition of a gain or loss when there is a reorganization, merger or consolidation between related parties, is to avoid the payment of costs not actually incurred by the parties. An overarching principle applicable under the Medicare statute and regulation, with which all reasonable cost regulations must be in accord, is the principle that Medicare will only share in costs actually incurred by the provider. Consistent with IRS rules, which recognize that no cost has been incurred under the foregoing facts, Medicare similarly does not find that the provider has incurred an actual cost for purposes of Medicare reimbursement under such facts.

II. Finding of Facts and Conclusion of Law.

This particular case involves a loss on disposal of assets claimed by the Provider as a result of a statutory merger. The Provider filed a terminating Medicare cost report for the fiscal year ending (FYE) August 31, 1997, which included a depreciation adjustment that recognized a loss on disposal of assets resulting from the merger. Upon audit of the Provider's cost reports the Intermediary issued a Notice of Program Reimbursement (NPR) dated May 26, 1999, denying the claimed loss of approximately $4,876,356.[23] The Provider timely appealed the NPR to the Board on November 12, 1999.

The Provider contended that the parties to this transaction were unrelated prior to the merger; therefore, the loss on disposal of assets is an allowable cost. The Provider argued that the regulations and PRM do not establish a "continuity of control" test applicable to mergers. The Provider argued that the "continuity of

[23] Intermediary's Exh. I-1.

control" test deals with entities related prior to the transaction. However, even if the related party rules apply to merger between unrelated parties, the merger between the Provider and New Germantown is a *bona fide* transaction.

The Administrator finds that based on a combination of factors the parties to the transaction (i.e., merger) are related through control. In applying the related party principles at 42 C.F.R. § 413.17, the Administrator finds that consideration must be given as to whether the composition of the new Board of Directors at New Germantown included significant representation from the Provider's Board or management team. If such is the case, then no real change of control of the assets has occurred and no gain or loss will be recognized as a result of this transaction. As stated above, the term "control" includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised. The ability to control does not require a majority representation. Notably, Section 1011.1 of the PRM, indicates that while any one individual factor might not constitute significant control, the combination of facts may indicate control. Further, HCFA Ruling 80-4 emphasizes that parties that had no relationship prior to an agreement could become related as a result of an agreement.

The Provider was a 258-licensed bed acute care hospital, a 22-bed hospital-based skilled nursing facility and a multistory medical office building. Germantown Medical Center Foundation (Foundation), was a Pennsylvania nonprofit corporation and was the sole corporate member of the Provider.

A Definitive Agreement was entered into between the Provider, the Foundation and Einstein Health Network on May 30, 1997, whereby Einstein agreed to acquire the Foundation together with the Provider by means of a merger of the Foundation and the Provider into "New Germantown."[24] Einstein Health Network served the Philadelphia area through its various health care facilities. The network included Albert Einstein Medical Center, a tertiary care and teaching hospital, Belmont Behavioral Health facilities, which offered treatment for mental disorders and addictions, and MossRehab, which offered physical therapy services. The health care network also operated a sub-acute care facility (Willowcrest) and a network of health clinics. Einstein was also a member of the Jefferson Health System a not-for-profit alliance of health systems and hospitals serving the Delaware Valley.

[24] Intermediary's Exh. I-2.

The record shows that New Germantown was a shell corporation, incorporated June 24, 1997, and a wholly owned subsidiary of Einstein created for the sole purpose of the merger.[25] On August 31, 1997, New Germantown acquired the Foundation and Provider, pursuant to a statutory merger.[26] The Provider transferred monetary and non-monetary assets.[27] In return, the New Germantown assumed liabilities and promised contingent consideration.[28]

The record shows that on February 28, 1997, which was many months prior to the creation of the New Germantown and the merger, the President and CEO of Einstein wrote a letter to the Provider's President and CEO stating that the parties intended to preserve the Provider's senior management.[29] Moreover, as noted a Definitive Agreement, dated May 30, 1997, was entered into between the Provider and Einstein the parent company of New Germantown. Notably, the definitive agreement was not between the Provider and the sole parent Foundation and the surviving entity, which had not yet been created, but rather between the Germantown parties and Einstein. In contrast, the merger agreement, dated September 1, 1997, was solely entered into between New Germantown (the wholly owned subsidiary of Einstein) and the Provider. Although the merger would appear to be between the Provider and the New Germantown, in fact, the merger was the result of a contractual relationship between the Provider and New Germantown's parent company. The contractual terms of the definitive agreement and prior actions between the Provider and Einstein had the effect of creating the "control" inherent to a related party relationship.

Pursuant to the Definitive Agreement six of the forty board members of New Germantown were former board members of the Provider.[30] The Chairman,

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[25] Provider's Exh. P-28 at 11.

[26] Provider's Exh. P-28. The merger agreement was dated September 1, 1997, with an effective date of the merger specified in the Articles of Merger. The record shows an undated copy of the Articles of Merger at P-28, Exhibit B.

[27] Provider's Exh.P-99. The non-monetary assets included land, buildings, equipment and intangibles appraised at $11,500,000 (Exh. P-102) with a book value of $14,520,942 (Exh. P-99) The monetary assets included endowments of $37,915,324.(Exh. P-99.)

[28] Intermediary's Exh. 27. As part of the agreement, Einstein was required to spend $6 million in support of the Provider's mission. Exh. I-2, P-24. The Provider disputes that the $6 million should be considered assets.

[29] Intermediary's Exh. I-6.

[30] Intermediary's Post-hearing Brief at 5; Intermediary's Exh. I-2 at 4. They included Earle N. Barber, Jr., James K. Monteith, Francis R. Strawbridge, III and Leon. W. Tucker. In addition, Bruce K. Brownstein, M.D. and David A. Ricci

President and Chief Executive Officer (CEO) and Vice Chairman of the Provider became Chairman, President and CEO and Vice Chairman of New Germantown. That is, the senior management of team of the Provider remained intact after the merger. Seven members of the Provider's board became board members of the parent corporation, Einstein. One member of the Provider's board was elected to the Einstein's Committee on Trusteeship, whose responsibilities included nominating members of governing New Germantown and two members of the Provider's board were elected to Einstein's Executive Committee that exercised authority and responsibility and decision making for the corporation of Einstein. In addition, testimony indicates that two medical staff members that had been previously on the medical staff of the Provider became medical staff board members on New Germantown.[31] Finally, testimony indicates that every remaining member of the Provider's board that expressed an interest was placed on either the New Germantown Board or the Einstein's board.[32]

The letter dated February 28, 1997, also shows that the entities were working in concert to obtain Medicare depreciation recapture monies for the successor entity, New Germantown, without any apparent benefit to the Provider.[33] The letter stated that: "AEHN and Germantown intend to agree on a mutually acceptable structure that will result in the creation of a new corporation that will own and operate the Foundation and its affiliated entities…. The structure will be designed, among other things, to attempt to ensure maximum Medicare depreciation recapture. Upon receipt, the recapture proceed will be used to repay Germantown's endowment fund borrowing…." To that end, the parties structured the transaction so as to have no more than 20 percent of the Provider's board serve as board member of New Germantown, in order to "ensure maximum Medicare depreciation recapture," for the benefit of the surviving entity.[34] This aspect of the transaction is further evidence of the Provider's strong identification with the surviving corporation as a continuation of the Provider.

In sum, the following are reflective of the Provider's expectation that the transaction was but a continuation of the Provider in another form. The mission

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were members of the governing board of the Provider. Intermediary's Exh. I-4 at 3.

[31] Transcript of Oral Hearing (Tr.) at 139.

[32] Tr. at 174, 175

[33] Intermediary's Exh. I-6 at 2. Tr. at 35, 171.

[34] Tr. at 172-173. (" Q. And how were you trying to structure this? Where you trying to keep the percentage board membership of the old entity on the new entity under a certain figure, certain percentage? A. Yes, 20 percent.")

of the New Germantown was identical to the Provider's community health care mission. There was a continuation of the Provider's former senior management team, board members and employees at the New Germantown. The Provider repeatedly acted for the benefit of the surviving corporation: It obtained an agreement with Einstein for six million in community access funds for New Germantown and it purposely structured the transaction to maximize reimbursement for New Germantown.

Based on the totality of the foregoing circumstances, the Administrator finds that the Provider and New Germantown can be considered related through significant affiliation both before and after the transaction. While the Provider did not have a majority interest in new Germantown's board the Administrator finds that it had a significant affiliation with Einstein the parent of New Germantown prior to the merger, and with New Germantown, subsequent to the merger, and that the Provider continued to have significant influence on the decisions affecting its assets, inter alia, through its board representation and the continuity of its senior management.

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

The Administrator finds 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 entity has but recast its interest in another form and no actual loss has been incurred. Reasonable costs rules must be interpreted consistent with this economic reality.

The Administrator also notes that the Board also made several findings regarding the interaction of the various regulations on 42 CFR §413.134(k).[35] The

[35] While not dispositive to this case, the Board has in the past concluded that the CMS policy on consolidation/mergers revaluations in the final rule published Feb

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 the specific consolidation requirement of 42 CFR §412.134(k). Paragraph (k) was drafted specifically to address the revaluation of assets for proprietary corporations, while paragraph (f) specifically addresses circumstances under which a gain or loss will be recognized. Paragraph (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).[36]

5, 1979 was a change from the proposed rule published in April 1, 1977. However, the final rule would appear to contradict that conclusion also made by the former CMS official. 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 policy Medicare policy and does not note any changes on consolidations as a result of comments. The change referenced from the proposed rule is that the final rule dedicates separate paragraphs to related and unrelated transactions involving consolidations, similar to that provided for statutory mergers. Thus, based on the foregoing, one could conclude that this change was to clarify the proposed language, rather than to promulgate a substantive change from the proposed rule.

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

In addition, 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.

In addition, the Administrator finds that the disposal of asset rules of paragraph (f) are properly applied in the event of a merger. 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 transfer of the assets did not

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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.")

constitute a "bona fide sale" as required under paragraph (f)(2) and the Provider failed to met any other criteria under which a loss on the disposal of assets will be recognized at §413.134(f).

As the PRM explains, "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. As also set forth in PM A-00-76, reasonable consideration is a required element of a *bona fide* sale. Therefore, a comparison of the sale price with the fair market value (FMV) of the assets is required.[37] A large disparity exists between the sale price (consideration) and the FMV indicates the lack of a *bona fide* sale. Moreover, the Administrator finds that in analyzing whether a *bona fide* sale has occurred, a review of the allocation of the sales price among the assets sold is appropriate. Examples of transactions that raise the issue a bona fide sale are set forth in PM A-00-76:

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

PM A-00-76 further states that:

> Non-monetary consideration, such as a seller's concession from a buyer that the buyer must continue to provide care for a period of time or to provide care to the indigent, may not be taken into account in evaluating the reasonableness of the overall consideration (even where such elements may be quantified in dollar terms). These factors are more akin to goodwill than to consideration.

In this case, 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. In particular, the Administrator notes that the Provider's President

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[37] 42 CFR § 413.134(b)(2) defines fair market value (FMV) as the price that *bona fide* sales are consummated for like type, quality, and quantity in a particular market at the time of acquisition.

and CEO testified that the Provider did not attempt to negotiate the best price for its assets. When the President/CEO was asked whether the Provider made a counteroffer to Einstein's offer to assume the liabilities in exchange for the assets, he commented that:

> A. We countered with the notion of trying to get additional contribution for the benefit of [New Germantown].
>
> Q. And what was your counter?
>
> A. We only were looking for additional funds. We didn't come back with a specific number, as I recall.[38]

The above exchange supports a conclusion that the Provider did not make a serious effort to negotiate the best price possible for its assets and in fact negotiated for the benefit of the surviving entity. The Provider was more concerned with community considerations and the future of the merged entity in the community rather than obtaining fair market value for its assets. The Provider's request for proposals make clear that community considerations were paramount and that fair market value was an afterthought.[39] However, community considerations may not be taken into account in evaluating the reasonableness of the overall consideration offered. Further evidence of the lack of an arms length transaction is seen in the Provider's failure to negotiate for its own benefit, as opposed to the benefit of the surviving entity, when it attempted to maximize Medicare depreciation reimbursement in the structuring of the transaction, reimbursement that was to be for the benefit of the surviving entity.

In addition, the Administrator finds that when offers from other potential buyer were received, the Provider did not follow-up on an offer that could have enable it to obtain the best sale price. The record shows that had the Provider successfully sold its fixed assets, inventory, etc., to another entity identified in the record, the Provider could have received $27 million more in consideration than

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[38] Tr. at 167.

[39] The Provider's request for proposals state that: "The principle objectives the Germantown Board expects to consider in evaluating the proposals will be to: (i) ensure that Germantown continues to serve the health care needs of its community; (ii) enhance the health care services available at Germantown . (iii) maintain, to the extent possible, Germantown's workforce; (iv) achieve a fair value for Germantown's business assets." Intermediary Exh. I-15.

its liabilities, (when the endowments funds are included as net proceeds.)[40] The Provider now states that such an offer was not realistic and would not have resulted in a contract. However, these reasons were not on its face self-evident at the time of the proposal and in part are comprised of conjectures. Thus, they do not explain the Provider's failure to follow-up at that time on this entity's proposal. It does suggest that interests, other than monetary, were more primary to a successful deal for the Provider.

Instead, the Provider transferred its assets, $57,920,172 in monetary assets and $14,520,942 in fixed assets (property, plant and equipment) for a total of $72,441,114[41] for the amount of liabilities on its books, $34,263,485, plus contingent consideration of $6 million[42] without receiving or seeking any additional compensation for the excess value of its assets over its liabilities. The Administrator finds that the large disparity of approximately $32 million, between the asset values and the consideration received, reflects the lack of arm's length bargaining, and thus the lack of a *bona fide* sale.[43]

In fact, the application of certain accounting principles plainly demonstrates that the Provider in effect transferred the depreciable assets for no consideration and, thus, the transaction failed to meet the criteria of a bona fide sale. For example, while Medicare does not specifically address the treatment of endowment funds, under GAAP such funds are defined as "assets" that should be disclosed on the

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[40] Intermediary's Post-Hearing Brief at 21; Provider's Exh. P-98. The Provider originally argued against this methodology that includes the endowments funds as part of the assets.

[41] Provider's Exh. P-99 at 2.

[42] Intermediary's Exh. I-2 at 4. Per the Definitive Agreement, Article I § 1.2, at the closing date, Einstein agreed to commit $6 million for the next five years to further the mission of New Germantown. In general, the funds were to be used to further the community to healthcare services, making investments in New Germantown's facilities, and expanding New Germantown's primary care network, and to insure continued access.

[43] A subsequent appraisal valued the Provider's fixed and intangible assets at $11.5 million (Exh. P-102), the validity of which is not conceded by CMM. CMM notes that the appraisal were completed after the sale, when it would have been in both parties interests to have a low appraisal. However, even assuming *arguendo*, CMS were to adopt that figure, there still remains a significant disparity between the "consideration" and the value of the transferred assets. Using this figure the assets transferred are valued at $69,420, 171. Exh.P-99.

balance sheet.[44] Thus, these assets would be considered in the valuation of the Provider's current, monetary and depreciable assets. Moreover, if the methodology of APB No. 16 is used to allocate the consideration, the consideration is first to be allocated to the identifiable monetary assets and the remaining amount pro rated to the non-monetary assets or the asset values not precisely known.

Using such methodology, it is clear that the value of the monetary assets far exceeded the consideration transferred (i.e., the value of its liabilities). That is, without conceding the loss methodology, to find a bona fide sale there is a *logical* inconsistency which must be forced upon this transaction. To find that any consideration was paid for the depreciable assets, a less than dollar-to-dollar allocation must be made to the monetary assets. When a dollar-to-dollar allocation is made to the current and monetary assets, it is shown that the Provider in this case in fact disposed of the depreciable property for no consideration. The Administrator finds that this is not reasonable consideration required of an arms length transaction and bona fide sale. Thus, the transaction fails to meet the criteria required under 42 CFR§ 413.134(f) for a loss on the disposal of assets to be recognized.[45]

In sum, the Administrator holds that Medicare cannot recognize a loss on the transfer of the assets because the parties were related and there was no bona fide sale as required under 42 CFR § 413.134(f).

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[44] The Provider seeks to allocate a portion of the "consideration" transferred in this transaction to these funds in order to increase Medicare reimbursement for purposes of determining the loss.

[45] As a loss cannot be allowed in this case, the Administrator does not reach the issue of how to calculate the loss on the disposal of assets.

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: 10/28/04 /s/

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