CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
New England Deaconess Hospital	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 09/30/96**
Provider	
vs.	
Blue Cross /Blue Shield Association/ National Government Services	**Review of: PRRB Dec. No. 2009-D24 Dated: May 29, 2009**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the Center for Medicare Management requesting reversal of the Board's decision. Comments were also received from the Provider requesting modification of 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 disallowance of the Provider's claim for a loss in connection with its October 1, 1996 statutory merger was proper.

The Board held that the Intermediary's adjustment disallowing the Provider's claimed loss on disposition of assets due to a change of ownership resulting from a statutory merger was contrary to the regulatory requirements of 42 C.F.R. §413.134(1)(2)(i) and reversed the Intermediary's decision. The Board also stated that the allocation of the consideration to the merged assets should be performed

based on the Provider's submitted appraisal using the pro-rata method discussed at 42 C.F.R. §413.134(f)(2)(iv).

The Board found that the Provider and the surviving hospital corporation, Beth Israel Hospital Association (BIHA), were unrelated parties as that term is defined under the regulatory provisions of 42 C.F.R. §413.7 and 42 C.F.R. §413.134. Accordingly, a revaluation of the assets and a recognition of the loss incurred as a result of the merger is required under the plain meaning of 42 C.F.R. §413.134(1)(2)(i).

The Board rejected the Intermediary's assertion that an examination of the relationship of both the parties prior to and after the merger is appropriate. The Board concluded that the plain language of the regulation barred application of the related party principle to post-merger relationships. The Board concluded that the regulation only required that the parties prior to the merger not be related. Furthermore, the Secretary's interpretive guidelines found at the Intermediary Manual (HCFA Pub. 13-4) §4502.6, which stated in part: "Medicare program policy permits a revaluation of assets affected by corporate mergers between unrelated parties" only helped to support the Board's determination.

The Board further found that the HCFA Ruling 80-4 is inapplicable because it does not apply to the facts in this case. This Ruling requires consideration of the relationship between unrelated parties according to the new rights created by their contract. The Board stated that the facts in this case show that this is a one-time transaction with one of the parties ceasing to exist. Therefore, there is no continuing relationship thereafter. Since no continuing relationship remained, there is no related party relationship under HCFA Ruling 80-4.

The Board found that even if the Provider had to prove it was unrelated after the merger, the Provider would nevertheless prevail. The Board stated that even though 30 percent of the surviving hospital entity and 34 percent of the surviving parent corporate Board of Directors were individuals who had previously served on the Provider's board, these individuals did not have the ability to significantly influence or control the surviving corporation as required by 42 C.F.R. §413.17(b)(3).

Finally the Board found that the transaction was not required to meet the criteria of a *bona fide* sale, only a *bona fide* transaction. The transaction was *bona fide* under the Black's Law Dictionary definition. The evidence clearly shows negotiations with several potential candidates. The merger itself was arm's length, between a willing and well informed buyer and seller, neither being under coercion, for reasonable consideration acting in its own self-interest. Finally, the Board found that the Provider received reasonable consideration. The Board determined that, after multiple failed negotiations, it was persuasive that having the Provider's liability

assumed through merger was the best price it could obtain. The Board differed with the Provider on the methodology to be used to allocate the loss.

SUMMARY OF COMMENTS

CMM Comments

CMM commented requesting that the Administrator reverse the Board's decision. CMM argued that the Board made several errors in its decision. First, the Board rejected the Intermediary's argument that there was a continuity of control that resulted in the parties to the merger being related. Under the regulation at 42 C.F.R. § 413.17 a provider may not claim a loss on depreciation if the sale was between related parties. Because of the Board's overly restrictive reading of the related party rule, it incorrectly concludes that the only relevant consideration is whether the parties were related prior to the merger. The Board's holding is erroneous and contrary to the CMS policy which is longstanding and has been upheld by the courts.

In this case, there was a carry forward of board members pre and post affiliation that allowed the Provider's former board members to significantly influence the surviving hospital. The new governing board of the surviving entity consisted of 40 voting members, 12 (or 30 percent) had previously served on the Provider's or its parent's board prior to the merger. Of the 11 trustees emeritus, four had served as trustees emeritus to the Provider, and one had served as an *ex officio* member of the Provider's board. After the merger, the surviving parent corporation (CareGroup) Board of Directors consisted of 29 persons, 10 of which formerly served as trustees, officers, or directors of the Provider or its parent Pathway. Eight members of the initial twenty-nine person CareGroup board, formerly had served on either the Provider's board or the Provider's parent board. Therefore, the Intermediary properly found that the merger was a related party transaction.

Second, the Board erred in finding that the merger was not subject to the *bona fide* sale according to Program Memorandum A-00-76. As set forth in the Provider Reimbursement Manual, (PRM) §104.24, reasonable consideration is required to be considered a *bona fide* sale. Therefore, there must not be a large difference between the consideration and the fair market value of the assets. In this case, the Intermediary found disparity between the "consideration" and the fair market value. Furthermore, the appraisal of the assets was not conducted until after the merger, which could affect the reflected value. There was no cash exchanged between the parties; there was only an assumption of assets and liabilities. Since the owner did not receive reasonable consideration, the transaction should not be treated as a *bona fide sale*.

Provider Comments

The Provider supported the Board's decision and requested affirmation of the Board's decision to allow the Provider's loss on disposal of assets resulting from its statutory merger with BIHA. The Provider also requested a modification of the Board's decision related to the computation of the loss.

The Provider stated that the Board's decision to allow the loss and to reject the Intermediary's reliance on Program Memorandum A-00-76 was proper. The Board correctly determined that the Program Memorandum A-00-76, issued almost four years after the Provider's transaction and not published in the Federal Register until almost six years after the Provider's merger, was not a clarification of policy, but a change in interpretation. The Administrative Procedure Act bars this type of retroactive application of the Program Memorandum's guidance.

The Provider also stated that the Board properly determined that the Provider's transaction was *bona fide*. The Board's finding, that there was reasonable consideration, is supported by the evidence in the record. The Provider's multiple unsuccessful attempts to make a business deal demonstrated that the ultimate assumption of its liabilities through a merger was the best price it could obtain. However, the Provider requested modification of the Board's decision regarding the computation of the loss.

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

A. Capital Related Costs.

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

Title VI of the Social Security Amendments of 1983[1] 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[2] 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

[1] Pub. Law 98-21.

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

> 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.[3]

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

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

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

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

[3] 44 Fed. Reg. 3980 (Jan 19, 1979).

> computation and treatment of gains and losses in determining reasonable costs. [4]

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. [5] (Emphasis added.)

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

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

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

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

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[4] 41 Fed. Reg. 35197 (August 20,1976) "Principles of Reimbursement for Provider Costs: Depreciation: Allowance for the Depreciation Based on Asset Costs." (Proposed rule.)

[5] 44 Fed. Reg. 3980. (1979) "Principles of Reimbursement for Provider Costs."(Final rule.)

> 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. [6]

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

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

Paragraph (f)(3) addresses gains or losses realized from sales within 1 year after the provider terminates from the program, while §413.134(f)(4) addresses exchange trade-in or donation[7] 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.

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

[7] 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.

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,[8] 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)[9] were promulgated to address longstanding Medicare policy regarding depreciable assets exchanged for capital stock, statutory mergers and consolidation. Concerning the valuation of assets, the regulation states that:

> (l) *Transactions involving a provider's capital stock—*
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> ****
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> (2) *Statutory merger*. A statutory merger is a combination of two or more corporations under the corporation laws of the State, with one of the corporations surviving. The surviving corporation acquires the assets and liabilities of the merged corporations(s) by operation of State law. The effect of a statutory merger upon Medicare reimbursement is as follow:
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> (i) *Statutory merger between unrelated parties*. If the statutory merge is between two or more corporations that are unrelated (as specified in §413.17), the assets of the merged corporation(s) acquired by the surviving corporation may be revalued in accordance with paragraph (g) of this section. If the merged corporation was a provider before the merger, then it is subject to the

[8] 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.

[9] (1995) Originally codified at 42 CFR §405.415(l).

> provisions of paragraphs (d) (3) and (f) of this section concerning recovery of accelerated depreciation and the realization of gains and losses. The basis of the assets owned by the surviving corporation are unaffected by the transaction. An example of this type of transaction is one in which Corporation A, a nonprovider, and Corporation B, the provider, are combined by a statutory merger, with Corporation A being the surviving corporation. In such a case the assets of Corporation B acquired by Corporation A may be revalued in accordance with paragraph (g) of this section.
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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.

The Administrator finds that, as the issue under appeal involves the recognition of depreciation losses on the transfers of assets from a merger between non-profit entities, he cannot limit his review to the specific merger requirements of 42 CFR §412.134(l). Paragraph (l) 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 (l) did not modify or limit the general related party rules at §413.17 and does not address or modify the criteria for recognizing 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).[10]

B. Related Organizations

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

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

Consistent with the Act and the regulations, the above principles are set forth in the Provider Reimbursement Manual or PRM, which provides guidelines and policies to

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[10] 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 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.")

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).[12] The Ruling pointed out

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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.)

[12] In Medical Center of Independence, supra, the court held that a medical center and a management corporation from which it leased and operated a hospital facility were related organizations within the meaning of § 413.17, where the management corporation had purchased the assets of the hospital and had entered into a 15 year lease agreement with the hospital, with a management agreement to run concurrently with the lease, and where six employees of the management corporation were elected as directors of the hospital, and two were elected as hospital officers. The court upheld the District Court's finding that the management corporation had the power, directly or indirectly, significantly to influence or direct the actions or policy of the

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

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

1. Program Memorandum A-00-76.

To clarify the application of 42 C.F.R.§ 413.134(l) to non-profit providers with respect to the related party rules and the rules on the disposal of depreciable assets, CMS issued Program Memorandum (PM) A-00-76, dated October 19, 2000. This PM applies the foregoing regulations to the situation of non-profit corporations. In particular, this PM noted that non-profits differ in significant ways from for–profit organizations. Non-profit organizations typically do not have equity interests (i.e., shareholders, partners), exist for reasons other then to provide goods and services for a profit, and may obtain significant resources from donors who do not expect to receive monetary repayment of or return on the resources they provide. These differences, among others, cause non-profit organizations to associate or affiliate through mergers or consolidations for reasons that may differ from the traditional for-profit merger or consolidations. In contrast, the regulations at 42 C.F.R. § 413.134(l) were written to address only for-profit mergers and consolidations.

The PM also noted that, unlike for-profit mergers or consolidations, which often involve a dispatching of the former governing body and/or management team, many non-profit mergers and consolidations involve the continuation, in whole or part, of the former governing board and/or management team. Thus, in applying the related organization principles of 42 C.F.R. § 413.17, CMS stated that consideration must be given to whether the composition of the new board of directors, or other governing body and/or management team include significant representation from the previous board or management team. If that is the case, no real change of control of the assets has occurred and no gain and loss may be recognized as a result of the transaction.

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hospital, and rejected a contention that potential influence, in the absence of a past and present exercise of influence, is insufficient to warrant a finding of control. The court stated that while the absence of any prior relationship between the parties is relevant to the issue of control, it should not automatically lead to the conclusion that the related party principle does not apply.

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

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

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

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

Notably, the Administrator finds that the requirement that the term "between related organizations" includes an examination of the relationship before and after a transaction of assets under 42 C.F.R. § 413.417 (§ 405.17), was applied as early as 1977 by the agency in evaluating whether accelerated depreciation would be

recaptured. The agency decided that "when the termination of the provider agreement results from a transaction between related organizations and the successor provider remains in the health insurance program and its asset bases are the same as those of the terminated providers, health insurances reimbursement is equitable to all parties": thus, the depreciation recovery provisions would not be applied.[13] 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.[14] Thus, the PM interpretation of the related party rules as requiring an examination of the relationship before and after the transfer of assets is consistent with early Medicare policy and HCFAR 80-4.

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

> Corporation A and Corporation B, both non-profit providers, are combined by statutory merger with Corporation A surviving. Corporations A and B were unrelated prior to the transaction, each being controlled by its respective Board of ten Directors. After the merger, Corporation A's new ten member Board of Directors includes five individuals that served on Corporation B's pre-merger board. Thus, Corporation A's new Board of Directors includes a significant number of individual from both of the former entities' boards. Because no significant change of control of the assets of former Corporation B has occurred, the transaction as between Corporation A and Corporation B is deemed to be between related parties and no gain or loss will be recognized as a result of the transaction. [15]

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

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[13] 42 Fed. Reg. 45897 (1977).

[14] 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.)

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

transaction is to determine the provider structure both before and after the transaction and to determine the type of transaction which occurred because Medicare has developed specific policies on the reimbursement effect of various types of CHOW transactions which may be different from treatment under generally accepted accounting principles or GAAP. Section 4502.1 list the various types of provider organizational structures and included as one possible type of provider organization are Corporations.

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

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

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

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

Section 4508.11 of the Intermediary Manual,[16] in addressing stock corporations states that, Medicare program policy places reliance on GAAP, as expressed in APB No. 16

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

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,[17] Intermediaries are instructed to refer to the principles outlined in the CHOW manual which specify when reference to APB No. 16 is in accordance with the current Medicare policy.

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

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

This policy of not recognizing a gain or loss when the transaction is between related parties, whether it constitutes a reorganization, consolidation or merger, is also consistent with Internal Revenue Service (IRS) rules on the non-recognition of a gain or loss when a statutory reorganization has been determined to have occurred. Relevant to this case, while the Medicare rules may diverge from IRS rules and Medicare policy is not bound by IRS policy, IRS policy often reflects rationale underlying the establishment of similar policies under Medicare.[18] In fact, in setting forth principles applicable to the recognition of the gain or a loss, CMS has in the

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[17] 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).

[18] 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).

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.[19]

Under IRS rules, some mergers are considered statutory reorganizations and subject to the non-recognition of a gain or loss. The terms reorganization and merger are not mutually exclusive terms under IRS rules. Medicare policy similarly indicates that they are not mutually exclusive terms under Medicare rules. That is, consolidations and mergers may in fact constitute in essence, reorganizations and reorganizations may involve more than one corporation.[20] For example, a merger where the predecessor corporation board continues significant control in the new corporation board is treated the same as reorganization for Medicare reimbursement purposes and no gain or loss is recognized. However, for example, where the predecessor corporation board does not continue significant control in the new corporation board, a gain or loss will be recognized for Medicare reimbursement purposes.

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

> The principle under which statutory reorganizations are not considered taxable events is that no substantial change has been affected either in the nature or the substance of the taxpayer's capital position, and no capital gain or loss has actually been realized. Such a reorganization contemplates a continuity of business enterprise and a continuity of interest and control accomplished [in this instance] by an exchange of stock for stock.[21] (Emphasis added.)

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

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

[21] 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

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."[22] 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."[23]

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

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

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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).

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

[23] 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)).

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

II. Finding of Facts and Conclusion of Law.

This particular case involves the Provider's claim for a loss on the disposal of assets as a result of a merger. New England Deaconess Hospital (Provider) was a 385-bed tertiary care surgical teaching hospital located in Boston, Massachusetts. On October 1, 1996, the Provider consummated a statutory merger with Beth Israel Hospital Association (BIHA), at which point the Provider ceased to exist. BIHA, as the surviving legal entity, changed its corporate name to Beth Israel Deaconess Medical Center, Inc. (BIDMC). The Secretary of the Commonwealth of Massachusetts issued a Certificate of Merger certifying to the Provider's statutory merger into BIHA. In accordance with the Provider Reimbursement Manual (PRM), Part I (CMS Pub. 15-1), §2412.2(A), the Provider filed a terminating cost report.

Simultaneously with the merger of the hospitals, the Provider's parent, Pathway Health Network, Inc. (Pathway) merged, along with Mount Auburn Foundation, Inc. (Mount Auburn), into the Beth Israel Corporation (BIC), the parent and sole member of the Beth Israel Hospital Association. BIC was the surviving legal entity of that statutory merger and changed its name to CareGroup, Inc. (CareGroup). The Secretary of the Commonwealth of Massachusetts certified the statutory merger of Pathway and Mount Auburn into Beth Israel Corporation. Pathway ceased to exist.

After the merger, the BIDMC (the surviving hospital entity) Board of Trustees consisted of 40 voting members. In addition, BIDMC had 11 designated non-voting trustees emeritus. Of the 40 voting members, 12 (or almost 30 percent) had previously served on the Provider or (its parent Pathway) board prior to the merger. Of the 11 trustees emeritus, four had served as trustees emeritus to the Provider, and one had served as an *ex officio* member of the Provider's board.

After the merger, the surviving parent CareGroup Board of Directors consisted of 29 persons, 10 of whom formerly served as trustees, officers, or directors of the Provider or its parent Pathway. Eight members of the initial twenty-nine person CareGroup board formerly served on the Pathway board. An additional two members of the initial CareGroup board had previously served on the Provider's board. In total, 34.5 percent of the initial CareGroup board had served previously on either the Provider's board or the Provider's parent board.

On August 31, 1998, the Provider filed an amended cost report claiming a loss of $8,370,165. On September 29, 1998, the Intermediary issued an NPR disallowing the Provider's loss.

A. Bona Fide Sale & Reasonable Consideration

Applying the foregoing provisions to the facts of this case, the Administrator finds that the Provider is not entitled to a loss on the disposal of assets because the Provider failed to show that there was a *bona fide* sale of its depreciable assets.[24] As stated above, a *bona fide* sale contemplates an arm's length transaction, between unrelated parties for reasonable consideration, with each party acting in its own self interest. As outlined in PM A-00-76, in evaluating whether a *bona fide* sale has occurred with respect to a merger or consolidation between or among nonprofit entities, a comparison of the sale price with the fair market value of the assets acquired is also required. A large disparity between the sale price (consideration) and the fair market value of the assets sold indicates the lack of a *bona fide* sale.

In allowing the loss, the Board concluded that the Provider's unsuccessful attempts to make a business deal with other health systems prior to the transaction involved in this case, is evidence that the assumption of the liabilities through merger was the best price it could obtain for its assets. However, as the Board also noted, the record is undisputed that the Provider was not seeking to sell its assets. Rather, the Provider was seeking to combine with another entity. Both the Provider's failed and successful negotiations involved a multitude of other non-economic factors that were not related to the disposition of its asset for the best price, yet were critical to the success or

[24] The Administrator finds the Board's proposal, that the merger need only be evaluated as to whether it was *bona fide* (e.g., honest, in good faith, etc.), rather than a *bona fide* sale, is erroneous. Not only is such a proposed standard not consistent with the plain language of the controlling regulation and Medicare policy, but such a standard does not ensure that the Medicare program is paying "reasonable costs."

failure of the merger attempts.[25] Consequently the Administrator finds that the history of the Provider's merger attempts does not reflect upon the value of its depreciable assets as such attempts were driven by matters other than sale price.

In this case, the record shows that the Provider transferred hospital assets that were not appraised before commencement with the merger or consolidation. The record shows that the Provider's strategy for the merger focused on expanding its services and to conduct a merger with an entity to deal with the Provider's cost and capital related issues.[26] The Provider was apparently not concerned about assessing whether the transaction was a "fair exchange." Instead, it focused on transitioning its debts and assets to BIHA for sheer "survivability" and to enable its organization to continue operations under a new name and company umbrella. The record shows that the Provider's Board was focused on the "total economic picture", the "balance sheet, income statements and before and after cash flows, as opposed to a valuation on the day of the transaction."[27]

The company assets consisting of a combination of land, building and fixed assets were exchanged for an assumption of liability of the Provider's debts by BIHA. At the time of the transaction, no "sales price" or "monetary value" was ever used to place a price on the transaction's worth or to represent value to either party. The only negotiated "value" evident in this transaction, was the noneconomic value associated with the transfer of a significant number of the Provider's Board members and directors to the surviving corporation.[28]

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[25] The Board characterized the Provider as rebuffed in its early affiliation attempts. However, the provider's merger attempts with New England Medical Center (NEMC) was reported as dying from a "thousand cuts." At that time NEMC was also reported as suffering from "financial woes", "urgent financial problems" and a "dysfunctional management." *See,* e.g , P-116, P-119. Hence, the weight of the evidence does not support a finding that the merger attempts failed, because of a significantly dimished of value of the Provider's assets.

[26] *See*, Transcript of Oral Hearing, p. 48.

[27] *See*, Transcript of Oral Hearing, p. 97.

[28] *See, e.g.*, P-51, Board Minutes of April 25, 1996 (showing that merger lacked any discussion of consideration)("This is basically the reason for the merger with Beth Israel – if we don't grow larger, we can't survive. While trying to lead very different institutions is a challenge, the common denominator of these two institutions is care of the patients. The negotiating team is trying to get as much balance as possible – we have talent and so do they."); Board Minutes from June 17, 1996, P-60. ("Mr. Horky reviewed the three party discussions which are currently underway. He noted that the consultant is doing an excellent job of quickly and efficiently identifying the common interests of the three parties in relation to what the essential characteristics

The absence of a calculation and determination of the value of the Provider's assets by the Provider before commencement of the transaction, to ensure that such assets were transferred to BIHA in a fair exchange is a strong indication that the Provider was not concerned with receiving reasonable consideration. The record shows that the Provider did not conduct an appraisal of assets until ten years after the merger and did so specifically for litigation purposes. In addition, the length of time between the commencement of the transaction and the eventual conduction of the appraisal and consequently, the documentation used for the appraisal, causes question of the validity of the appraisal. Hence, the absorption of the Provider's debt by BIHA, without any additional evaluation of the reasonable consideration of the provider's assets, does not support a finding that the Provider was involved in a transaction that involved *bona fide* bargaining at arms' length between well-informed parties, each acting in its own self interest.

In addition, the Provider transferred a combination of current, fixed and cash assets valued at approximately $355 million in exchanged for the surviving entity's assumption of liability of approximately $251 million. This resulted in approximately $100 million being transferred in excess of the debt. In essence, the Provider contributed over $100 million dollars in excess of debt to the new organization in return for such non-economical benefits as the almost 30 percent representation of its former board member on the BIHA and parent boards and continuing management presence.

In particular, the record shows that the total net book value of the Provider's depreciable assets, and land was approximately $212,000,000 and its current cash assets were valued approximately at $143,000,000 for a total of approximately $355,000,000 in assets. Thus, the Providers depreciable assets were transferred for approximately 50 percent of their net book value. This significant difference between the "sale" price and the only contemporaneously determined valuation of the depreciable assets does not constitute reasonable consideration.[29]

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of the system should be. These are: to develop a strong regional healthcare system, provide a continuum of excellent value added personalized health services to its involved population, balancing academic and community values, and promoting collaborative participation among the members of the system.") The minutes go on to discuss potential reservation of powers for the new corporation, governance issues and management issues. Again, as in all the other board minutes, transaction documents and proposals, no record of the negations for the best sale price is recorded.

[29] The Provider received an appraisal which was sent directly to the Provider's counsel on February 14, 2007. The appraisal shows a combined tangible property

Since there was a disparity of consideration tendered in exchange for the Provider's assets, the transaction in essence amounted to a combination between the two parties, rather than a *bona fide* sale of assets. This economic reality is also evident in the fact that, for accounting purposes after the merger, the assets were treated as a pooling of interests in the surviving entities books. The pooling of interest results in no re-evaluation of the assets or recording of a gain or loss because there is a continuation of ownership.

In sum, as noted above a *bona fide* sale must be for reasonable consideration. There is no documentation in the record as to why, or even whether, the parties thought that assumption of debt was fair consideration for the Provider's assets. Thus, the Administrator finds that, that the transaction was not a *bona fide* sale as required under the regulations and PRM for the recognition of a loss on the disposal of assets.

B. Continuity & Control

Furthermore, the Administrator finds that there was a continuity of control that resulted in the parties to the merger being related. As discussed above, a provider may not claim a loss on depreciation if the sale was between related parties. In this case, the record shows that there was a carry forward of top executives and board members pre and post affiliation that maintained the influence of the Provider and its parent company.

The economic reality that the transaction was a combination or reorganization, rather than a sale, becomes even more evident in light of the percent of corporate officers, directors and board members that transitioned from positions within the Provider's entity to new positions within the surviving entities are taken into consideration. The Provider and its parent company both represented an approximately 30 percent of its

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value of approximately $178,250,000 as a retrospective fair market value of the Provider's depreciable assets and land as of October 1, 1996. The compositions of the appraisal consisted of land, buildings, site improvement and fixtures. See, provider Exhibit P-126. Even if one were to adopt the Provider's appraisal, conducted ten years after the transaction, as the best measure of the fair market value of the Provider's assets, the approximately $178,000,000 of depreciable assets and land were transferred for $108,000,000 or approximately 60 percent of the alleged fair market value.

top officers, directors and board members on the surviving hospital corporation and the parent company board.[30]

There were several major entities that played a key factor in the transaction's orchestration. Deaconess (the Provider), Pathway's (the Provider's parent company), Mount Auburn Foundation and Beth Israel (parent of BIH). Since the inception of the negotiations, the Chief Financial Officers and or Presidents for the companies played instrumental roles in effectuating the merger.[31] In fact, after the merger, all CFOs/presidents had new positions in the merged parent organizations and as applicable in the surviving hospital entity[32] with the expectation that after three years roles would be reversed. The Provider knew that a greater representation on the Board would have give the Provider a greater influence and control to maintain its traditional corporate approach in handling issues within different medical departments and also the operations of the hospital.[33] However, that factor was balanced with what its leaders perceived was a greater understanding than Beth Israel had, of the need for the merger for both parties and hence the greater willingness to contribute "good will" to the endeavor.[34]

In addition, while a board representation greater than 30 percent might have translated into more influence and control, the Provider's own witness pointed out that no one individual could influence the new board because of the consensus building nature of the non-profit board environment. This observed board environment would also allow for the continued opportunity for influence and control

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[30] The record does not explicitly indicate the number of representations of Mt Auburn on the parent board and senior management, however, in the least that entity was represented by one member on the board and in senior management.

[31] *See*, Transcript of Oral Hearing, p. 133.

[32] While Mount Auburn, the parent, merged with the parent companies, the Mount Auburn hospital did not merge at the hospital level with BIDMC and therefore would not be expected to have any representation on that board.

[33] *See*, e.g. Transcript of Oral Hearing, p. 301. The percentage of board members that transferred into the newly merged companies was consistent with the number of parents merging and also, whether by plan or otherwise, at the hospital level, with the percentage of revenue the Provider and Beth Israel respectively brought to the merger.

[34] In addition, it would appear that one of the drivers of the merger was the head to head competition of the members of this merger with another Harvard Medical school associated network, Partners Health System, which had $1.8 billion in revenue based on its larger size and, hence, the merged entities future plans to further grow its one billion dollars in revenue through more mergers.

by the Provider's former members through the consensus building nature of the non-profit board.

The Provider also points to the intense staff infighting that occurred following the merger as evidence of the "takeover" by Beth Israel. However, the power struggle and cultural clash on the staff level, that seemed to have started with the nurses, would appear to have been an outcome of the merger that was not expected by any of the parties and, in the end, resulted in the eventual replacement of upper level management with a outsiders/neutral party to both entities.[35]

In sum, the Administrator finds that as the merger did not involve an arm's length transaction, between unrelated parties for reasonable consideration, with each party acting in its own self interest, a loss cannot be allowed in this case. As a loss is not allowable in this case, the Administrator does not reach the issue of how to calculate the loss.

[35] The newspaper reported "and five long years [after the merger] staffers fought over issues large and small" and described it as a "poisonous culture clash." P-122.

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: 7/24/2009

/s/
Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services