CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Jeanes Hospital **Provider** **vs.** **Wisconsin Physicians Service (Formerly Mutual of Omaha Insurance Company)** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 06/30/96** **Review of:** **PRRB Dec. No. 2009-D23** **Dated: May 27, 2009**

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 Providers 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.

BACKGROUND

The Provider, Jeanes Hospital, is a general acute care hospital located in Philadelphia, Pennsylvania. Pursuant to the terms of a November 17, 1995 affiliation agreement, the Provider merged on July 1, 1996, with Temple Central Hospital, Inc. Subsequently, the Provider ceased to exist as a separate corporate entity. Valuation counselors issued an appraisal of Jeanes Hospital on September 18, 1996. The Intermediary conducted a field audit in November of 1997 and issued a Notice of Amount of Program Reimbursement on May 28, 1998, for the

fiscal year ended June 30, 1996, disallowing the claimed loss on sale on the grounds that the transaction was a merger between related parties and not a *bona fide* sale. The Provider appealed the intermediary's adjustment removing the claim for a loss on sale.

The Board initially held an oral hearing on July 1, 2002, and issued Decision No. 2003-D62 on September 26, 2003, ruling in favor of the Provider. The Administrator reversed the Board's decision on November 25, 2003. The Administrator found that, inter alia, because a significant number of members from the Provider's board of directors transferred to the board of the surviving entity and because senior officers of the Provider continued as senior officers of the post-merger hospital, there was continuity of control between the Provider and the surviving entity.[1] The Administrator also found that the transaction was not at arms' length because, inter alia, the Provider did not seek to maximize the payment it would receive for its assets through a merger partner. The Administrator found, inter alia, that the amount of consideration received by the Provider reflected a "lack of motivation" to seek payment, and the large loss incurred did not support a finding that the transaction was a *bona fide* sale.

The Provider appealed the Administrator's decision to the United States District Court for the Eastern of Pennsylvania. The Court reversed the Administrator's decision that the parties were related but remanded the case for further fact finding on the fair market value of the depreciable assets, as required for a determination of whether a *bona fide* sale occurred.[2] The Administrator issued a remand order, dated March 5, 2007, returning the case to the Board for further proceedings consistent with the Court's order.

ISSUE AND BOARD'S DECISION

The issue is whether the Provider's merger was a bona fide sale.

The Board found that the fair market value of the Provider's assets was $69,214,000, because that price was the outcome of a *bona fide* bargaining at arms length between well-informed parties each acting it its own self-interest. The Board held that the consideration received by the Provider of $69,214,000 (i.e., $68,214,000 in liabilities assumed plus $1,000,000 paid to the Anna T. Jeanes Foundation) for its assets was reasonable when compared to the fair market value (or FMV) of those assets, $71,969,000. The Board's determination

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[1] Admr. Dec. 2003-D-62 (November 25, 2003).

[2] *Jeanes Hospital vs. Leavitt*, 453 F. Supp. 2d 888, 900 (E.D.PA)(September 29, 2006); Med & Med GD (CCH) ¶ 301,915

was based on an appraisal conducted by Valuation Counselors approximately two months after the merger that valued the fair market value of the Provider's land and depreciable assets at $30,100,000.[3] Thus, the total value of the Provider's cash and other current assets was approximately $41,869,000, thus, the total appraised fair market value of the Provider's assets was $71,969,000. The Board found that the consideration paid was comparable to the fair market value. Therefore, the loss claimed by the Provider based on the disposal of its depreciable assets resulting from the merger, was proper.

SUMMARY OF COMMENTS

Provider's Comments

The Provider commented requesting that the Administrator affirm the Board's decision. The Provider stated that the Board correctly determined that the price paid by Temple for the Provider was determined through arm's length negotiation, and the amount of liabilities assumed by Temple plus the $1,000,000 paid to the Anna T. Jeanes Foundation was a *bona fide* sale, The Board properly rejected the cost approach because that estimation did not take into account the depreciation due to external obsolescence and did not purport to be a proper determination of fair market value. The Provider disagreed with the Intermediary's position that income from the Anna t. Jeanes perpetual trust should be counted as an asset, since the Trust is held by a third party, not the Provider. The Provider stated that the Board properly determined that the amount paid by Temple for Jeanes Hospital assets were reasonable compensation for the assets and, therefore, the transaction met the Medicare requirements for a *bona fide* sale.

Intermediary Comments

The Intermediary submitted comments requesting that the Administrator reverse the Board's decision. The Intermediary noted that there was no appraisal of the Provider's facilities prior to the merger. Therefore, the Intermediary questions the propriety of the appraisal at issue. Furthermore, since the appraisal was not based on the cost approach it did not measure the fair market value of each of the Provider's assets as required by 42 C.F.R §413.134(f)(2)(iv). Finally, the Intermediary argued that the disparity analysis between the consideration paid for the Provider's assets and the value based on financial assets and the appraisers cost approach methodology of those assets indicates a lack of a *bona fide* sale.

[3] Provider's Exhibit P-35 at 22.

The Board erroneously concluded that the Intermediary relied on the net book value it its analysis when it used the GAAP value of current assets (which approximates fair market value) and the appraised value of the land and depreciated assets. In this case, the Provider surrendered $103.4 million in assets for Temple's assumption of $67.7 million in debt and a one million dollar donation to the Anna T. Jeans Foundation. In essence, the assets were transferred for 66 cents on the dollar.

CMM Comments

CMM submitted comments requesting that the Administrator reverse the Board's decision. 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.

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

A. Capital Related Costs.

Reasonable costs include capital-related costs. Consistent with the Secretary's rulemaking authority, the Secretary promulgated 42 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[4] 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[5] amended subsection (a)(4) of §1886 of the Act to add a last sentence, which specifies that the term "operating costs of inpatient hospital services", does not include "capital-related costs (as defined by the Secretary for periods before October 1, 1986)...." That provision was subsequently amended until finally, §4006(b) of OBRA 1987 revised §1886(g)(1) of the Act to require the Secretary to establish a prospective payment system for the capital-related costs of PPS hospitals for cost reporting periods beginning in fiscal year (FY) 1992.

1. Depreciation.

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

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

[4] Pub. Law 98-21.

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

> Medicare pays the actual cost the provider incurred in using the asset for patient care.[6]

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 computation and treatment of gains and losses in determining reasonable costs. [7]

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[6] 44 Fed. Reg. 3980 (Jan 19, 1979).

[7] 41 Fed. Reg. 35197 (August 20,1976) "Principles of Reimbursement for Provider Costs: Depreciation: Allowance for the Depreciation Based on Asset Costs." (Proposed rule.)

In adopting the final rule, the Secretary again explained that:

> Existing regulations contain a requirement that any gain or loss realized on the disposal of a depreciable asset must be included in Medicare allowable costs computations… The regulations, however, specify neither the procedures for computation of the gain or loss nor the methods for making adjustment to depreciation. These amendments provide the rules for the treatment of gain or loss depending upon the manner of disposition of the assets. [8] (Emphasis added.)

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

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

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

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

[8] 44 Fed. Reg. 3980. (1979) "Principles of Reimbursement for Provider Costs."(Final rule.)

> 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. [9]

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[10] 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

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

[10] 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.

has been an involuntary conversion, such as condemnation, fire, theft or other casualty.

2. Revaluation of Assets.

Historically, as reflected in the regulation, the disposal of a depreciable asset used to render patient care may result in two separate and distinct reimbursement events: 1) the calculation of a gain or loss for the prior owner and 2) a revaluation of the depreciable basis for the new owner. While the determination of gains and losses is generally only of interest to the prior owner,[11] the new owner in the same transaction is interested in the determination of when Medicare will allow the revaluation of depreciation for purposes of calculating the new owner's depreciation expense.

This latter issue, on the revaluation of assets, was the subject of significant litigation for the Medicare program regarding complex transaction and resulted in agency rulemaking on the subject. In response to litigation, the regulations at 42 C.F.R .§413.134(l)[12] 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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> (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

[11] 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.

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

> paragraph (g) of this section. If the merged corporation was a provider before the merger, then it is subject to the provisions of paragraphs (d)(3) and (f) of this section concerning recovery of accelerated depreciation and the realization of gains and losses. The basis of the assets owned by the surviving corporation are unaffected by the transaction. An example of this type of transaction is one in which Corporation A, a nonprovider, and Corporation B, the provider, are combined by a statutory merger, with Corporation A being the surviving corporation. In such a case the assets of Corporation B acquired by Corporation A may be revalued in accordance with paragraph (g) of this section.
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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 circumstance 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).[13]

B. 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.

[13] 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 (1) 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.")

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. As the PM indicates, 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.[14]

In determining reasonable consideration, the PM stated that:

> Appraisals may be relied on to establish the fair market value of depreciable assets. (See PRM §134ff.) However, caution must be taken in evaluating the appropriateness of the valuations established by appraisal for the purpose of this comparison.
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> The three most common valuation methodologies are the "cost approach," the "market approach," and the "income approach." A single appraisal may use one or more of these methodologies to arrive at a valuation of the entity. The cost is the only methodology that produces a discrete indication of the value for the individual assets of the business, and thus, is the approach that is used to allocate a lump sum sales price among the assets sold. (See 42 CFR 413.134(f)(2)(iv).) The market approach produces an estimate of value by comparing the entity being valued to sales of similar businesses. The income approach produces a valuation through analysis of the predicted future stream of income. Both the market approach and the income approach produce a valuation of the

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

> business enterprise as a whole, without regard to the individual fair market values of the constituent assets. As a result, both the market approach and the income approach could produce an entity valuation that is less than the market value of the current assets. Moreover, the income approach has minimal application in the non-profit sector because 1) earnings are often understated due to charity care, pricing limitations, and government regulations, and 20 the approach uses complex formulae that include some factors that are of questionable use in valuing non-profit entities (e.g., common stock risk premium). For the foregoing reasons, the cost approach is the most appropriate methodology to be used in establishing the fair market value of the assets sold for the purpose of comparison with the sales price in a bona fide sale analysis.[15]

In summarizing, the PM stated, "An arm's length transaction is a transaction negotiated by unrelated parties, each acting in its own self interest in which objective value is defined after selfish bargaining." With respect to reasonable consideration, the PM stated that the sales price should be compared to the fair market value of the assets and that a "large disparity between the sales price (consideration) and the fair market value of the assets sold indicates the lack of a *bona fide* sale." Finally, the PM stated that the "cost approach" (rather than the "market approach" or "income approach") was the "most appropriate methodology to be used in establishing the fair market value of the assets sold for the purpose of comparison with the sales price in a *bona fide* sale analysis.

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

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

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[15] Id. at 4.

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 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

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[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."

[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).

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 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]

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[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).

[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

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 a reorganization for Medicare reimbursement purposes and no gain or loss is recognized. However, for example, where the predecessor corporation board does not continue significant control in the new corporation board, a gain or loss will be recognized for Medicare reimbursement purposes.

Similar to Medicare rules, the IRS does not allow the recognition of the gain or loss when there is a 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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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).

[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 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

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.

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

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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)).

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 a claim for the loss on the disposal of assets when the Provider, pursuant to the terms of an Affiliation Agreement, dated November 17, 1995, merged with Temple Central Hospital, Inc., (TCH) a subsidiary of Temple University Health System, Inc., (TUHS). The effective date of the merger was July 1, 1996. TCH was the surviving entity and was renamed Jeanes Hospital (JH) after the merger.[24]

The court remanded the case to the Secretary for the limited issue of determining whether the transaction involved a *bona fide* sale. Applying the laws, manuals, program guidance and CMS policy to the facts and issue, on remand, the Administrator finds that the Provider is not entitled to reimbursement for a loss on sale because the criteria for a bona fide sale were not met. The Administrator finds that the transaction did not involve *bona fide* bargaining at arm's length between well informed parties, with each party acting in its own self interest.

The Board first found that the Provider explored the market for a suitable merger partners before entering into discussions with Temple. While the Provider engaged in discussions with other institutions before electing to merge with Temple, the Administrator finds that those negotiations primarily concerned: the role that the Provider's board would play in the post-merged entity; the postmerger mission; and ensuring the continuation of Jeanes Hospital as a viable hospital and health care provider in the community. These explorations did not involve seeking out the best purchase price for the Provider's assets.

For example, as early as the August 12, 1994 board minutes, Mr. LeFever, chairman of the Foundation board, reminded the board of the "early decision by

[24] TCH, a Pennsylvania nonprofit corporation was formed for the purpose of merging the Provider with TCH, thereby acquiring the assets and liabilities of the Provider.

the board to remain a health care provider for the community and to seek out an academic partner to ally with." Mr. LeFever reviewed the progress that the executive committee had made in identifying the best partner for the future delivery of care to the Jeanes community.[25] Major points to be explored during the due diligence process were to include, but not be limited to, the following: "Quaker history and presence; Quaker board; Academic programs; pastoral care programs and presence."[26] At that time, the board approved the executive committee's recommendation that Jeanes Health System sign a letter of confidentiality for the purpose of exploring a corporate affiliation with the University of Pennsylvania Health System.

In addition, the Provider's board minutes of October 22, 1994,[27] in discussing proposed affiliations, again did not include any transfer price concern, but instead focused on the issue of teaching affiliation, governance issues and Quaker values.[28] Similarly, the May 12, 1995 (A.R. 446) board minutes makes no reference to transfer price when evaluating and comparing possible affiliates, and choosing to enter into discussions with Temple, stating that:

> There was only one agenda item-the review and comparison of the proposals for affiliation from the University Of Pennsylvania Health System and Temple Health System: comparisons were made in the areas of proposed medical staff interaction, teaching programs, pastoral care program, primary network development as well as proposed efficiencies.
> After considerable discussions, the board agreed to proceed with a letter of intent with the Temple Health System.[29]

Consequently, from the start, the Provider's concerns regarding any proposed affiliation consistently did not include any concern for seeking the best economic gain for Provider and that continued when it chose to enter into discussions with Temple about a possible affiliation.

Regarding the discussions with Temple, the Board found that the Provider had been involved in extensive and lengthy negotiations with Temple prior to the

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[25] Administrative Record (A.R.) 425.
[26] A.R. 425-426.
[27] A.R. 436.
[28] See also A.R. 439 Memorandum of Understanding with University of Pennsylvania.
[29] A.R. 446.

merger showing that a *bona fide* sale had occurred. The extent of the negotiations for the "debt assumption" is one factor in demonstrating that the "sale" price was the result of a bona fide bargaining at arm's length between well informed parties, with each party acting in its own self interest. The Provider's witness, Mr. Lux, Temple Vice-President, stated at the most recent hearing (October 30, 2007 Oral Hearing), regarding the negotiations, that:

> Well if memory serves me correctly the payment at the foundation started in around three to five million range and ended at a million. There were discussions from my end saying that I really didn't think I [Temple] should have to absorb the debt given the value of the assets. The Jeans folks argued vehemently to the contrary.[30]

Mr Lux's testimony, pursuant to questioning by the Provider's representative further explained about the "debt" negotiations that:

> ….
> Q….. Now the million dollar payment went to Anna Jeans Foundation correct, which was unrelated to Temple? And they were the Foundation set up by the sellers, the Quakers, is that right?
> A. That's correct.
> Q. And the liabilities were assumed by a subsidiary of Temple UHS. But previously the liabilities were the responsibility of the Quakers is that correct?
> A. That is correct.[31]

However, a further review of the record shows that the debt negotiations did not involve the amount of the "debt or consideration" to be assumed. Mr. Lux testified at the early hearing (July 1, 2002 Oral Hearing) on how he handled a particularly aggressive member of the Provider's board, that:

> [W]e said to them … you are coming into a company, and we take responsibility for you, They wanted to take it one step further…. [Jeanes] said well that is okay but I want you to be more responsible for the debt, the long term debt, the $50 million in bond debt….. And we said we are not setting up our health system that way. We [Temple] are not as a matter of philosophy and structure wanting to go into joint and severable liability arrangements around long-term debt with our affiliates because we want our affiliates to operate and feel the pressures of delivering a bottom line … ..So we

[30] Transcript of Oral Hearing (Tr.) 108
[31] Tr. 115.

> said we are not going to guarantee any of the debt. We are not going to have another company within Temple Health System guarantee the debt of the new Jeanes Hospital, thereby preserving our ability as difficult as it could be to say … if the new Jeanes can't make it file for bankruptcy and it can restructure itself…. I don't have to pay for the debt when that happens.[32]

Thus, the intense negotiations between the Provider and Temple did not involve the amount of consideration that old Jeanes (the Provider) should receive for its assets, but rather involved which entity, the new Jeanes or the parent Temple, would be transferred the assumption of the liabilities. Temple negotiated with the Provider (the old Jeanes) to have the new Jeanes assume the liability for the debt, the same new Jeanes that would continue to be operated on a day-to-day basis by the old Jeanes management and a significant number of the old board members who in turn would have the financial responsibility for managing those same liabilities. Because Temple refused to assume the debt, the Provider negotiated to have Temple set up a four million dollar line of credit for the benefit of the new Jeanes in the event it had trouble meeting its obligations.[33] This action again emphasizes the Provider's failure to negotiate for its own economic benefit, but rather its consistent actions in negotiating for the future benefit and well being of of the new Jeanes.

Further, according to the minutes from the board meeting when the affiliation with Temple was approved, the record shows that the primary benefits to the Provider with the proposed affiliation with Temple included: "(a) the preservation of the Friends' [of Quakers] influence on the Hospital's mission and governance; (b) the preservation of existing Jeanes Hospital medical staff departments and the creation of various residency programs; and (c) the ability to continue to provide quality patient care in an environment marked by physician practice acquisitions and managed care completion."[34] One board member also commented that: "Temple's commitment to Jeanes System Management's continuing involvement, as well as Temple's agreement to cause the 'new' Jeanes Hospital Board to govern by consensus, represented unique aspects of the proposed affiliation contrast with other affiliations of this type."[35] Finally, Temple's vice-president, Mr. Lux, stated when questioned about the merger with Temple, that:

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[32] A.R. 217.
[33] A.R. 217.
[34] A.R. 1001. Jeanes Hospital Board of Directors minutes, dated October 28, 1995.
[35] Id.

> What was important to Jeanes [board] … was that they be permitted to continue to be involved in the day-to-day operations of the hospital or be part of it some fashion… We said, well, we can't have - we have got to have the majority control at the end of the day. And so we figured as long as we had majority control, we were okay. And as long as we could collapse the Board and reappoint a Board, we would be okay. And as long as we could have really substantial reserved powers. But it was more important to the Jeanes Board members that they had the ability to continue to be involved."[36]

Thus, a totality of the evidence supports the conclusion that there was no arm's length negotiations between a buyer and seller that each acted in its own economic self-interest.

The negotiations also involved certain other commitments to be made by Temple, commitments for which the benefits again inured to the new Jeanes, including $7 million for the development of a primary care physician network.[37]

> Q. And did these commitments for the program additions and complying with debt covenants and funding losses for the adult daycare program did they have value to the seller. Were they an inducement to the merger and did they have a value to them.
> A. … they clearly had value to the old Jeanes board for the following -at the following levels. One is the old Jeanes board, many of these people had spent years and years in close association with Jeanes, obviously interested in Jeanes continuing to survive in the market and continuing to hold true to the community based healthcare mission, and research and teaching in the small areas that they could do that… So the value to the old Jeanes people was more the preservation of what they knew in the past , the value—*the tangible value of what we did accrued to the new Jeanes hospital now part of Temple by stabilizing and growing its revenue streams*.[38] (Emphasis added.)

Finally, the negotiation for the contribution of one million to the Anna T. Jeanes Foundation, was a contribution to an entity that, at the time of the negotiations, was intended to be related to the new Jeanes. The re-formed foundation was intended to share Jeanes Hospital's past and present board members and had the

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[36] Id. at A.R. 218.
[37] A.R. 627.
[38] A.R. 223.

power to appoint board members to the new Jeanes. Prior to the merger, this intent was reflected in the January 27, 1996 Board minutes, which stated that:

> There was a discussion with regard to Jeanes System Management Company and its role after the Temple affiliation is completed. JSM will become the new Anne T. Jeanes Foundation … Board members were asked to start thinking about on which board they would prefer to sit. Board members could also decide to be on both boards.

The vigorous negotiation over the "consideration" to be paid by Temple to the Foundation was again not an economic benefit for the Provider, but rather was pressed for the economic benefit of an entity that was intended to be related to the new Jeanes and, with which, the new Jeanes shared a similar mission.

In addition, the record shows that the Provider transferred assets with a reported value in its financial statement of over $112 million in exchange for the assumption of debt, plus other considerations, in an amount reported as approximately $69 million. The record shows that when the Intermediary requested documents[39] relating to, or evidencing, an appraisal of the Provider's assets before the merger, the Provider stated "there was no appraisal before the transaction."[40] In fact, the record shows that an appraisal of the Provider's assets was not completed until after the merger became effective.[41] Thus, at the time of the merger, the "seller" only had before it the financial statements and net book value upon which to base its conditions for merger. Based upon these documents, the Provider transferred its assets for approximately 62 percent of the reported value. If the parties to the merger had intended to treat the merger as an actual sale of assets from one entity to the other, one would expect that, in order to be a well informed seller, the appraisal would have been completed before the transaction as basis for the negotiation of a purchase price. Consequently on its face, the transaction does not reflect the characteristics of a *bona fide* sale including bargaining at arm length between well informed parties, with each party acting in its own self interest.

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[39] Intermediary's Exhibit I-3.

[40] Intermediary's Exhibit I-4.

[41] A.R. 136. The witness for Temple stated that they did not need an appraisal as the sale moved forward based on his due diligence examining, in essence, whether they could carry the debt load based on income stream, controlling costs, etc, by the old Jeans management. Tr. 108.

The Board adopted the Valuation Counselors' use of the income approach to determine the fair market value of the Provider's assets.[42] The Valuation Counselors' income approach appraised the Provider's tangible and intangible assets at $30,100,000.[43] The Board determined that the Provider's cash and other current assets on June 30, 1996 were valued at approximately $41,896,000.[44] Thus, the fair market value of the Provider's total assets, when using the income approach totaled $71,969,000. Because the Board agreed with the Provider's use of the income approach to determine the fair market value of the Provider's assets, it held that the consideration received by the Provider of $69,214,000 (i.e., $68,214,000 in liabilities assumed, plus $1,000,000 paid to the Anna T. Jeanes Foundation) was reasonable when compared to the fair market value of those assets.

Even if one was to use the Valuation Counselors' appraisal conducted after the merger was completed by the surviving entity (the new Jeanes) and not the Provider, the Administrator finds that the reproduction (replacement) cost approach is the only methodology that assigns a value to each individual asset which is necessary under the Medicare rules and, thus, is necessary for the determining of the fair market value of the various depreciable assets. The Administrator finds that the replacement cost/cost approach is the most appropriate methodology to use in establishing the fair market value of assets sold for the purpose of comparison with the sales price in a *bona fide* sale analysis. Moreover, the cost approach is generally viewed as the only reliable approach when dealing with special use properties or when there is a lack of market activity.

In contrast, the income approach relies upon an analysis of the predicted future income of the business enterprise as a whole without any regard to the individual value of any of the depreciable assets. As the Program Memorandum also explained, the income approach has minimal application in the non-profit sector because earnings are often understated due to charity care, pricing limitations, and government regulations, and the approach uses complex formulae that include some factors that are of questionable use in valuing non-profit entities (e.g., common stock risk premium). The Provider's own witness confirmed the inadequacies of using the income approach. For example, when questioned, the Provider's witness acknowledged that the income approach did not measure the fair market value of each depreciable asset as required by the regulation.[45] When

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[42] Provider's Exhibit P-35 at 2. A.R. 137.
[43] Id.
[44] Provider's Exhibit P-37 at 2.
[45] Tr. At 64.

questioned whether the income method valued the individual assets in its depreciated state, the witness again responded "No."[46]

Notably, the appraisal itself states that:

> Capitalization of Income Approach: This valuation approach recognizes that the underlying value of the operating tangible and intangible assets can be represented by a stream of earnings. *This approach reflects earning power as an essential variable in a business enterprise.* Similar to the Sales Comparison approach, *the Capitalization of Income Approach provides an indication of value for a going business enterprise, but does not provide discrete indications of value for the assets of the business.* (Emphasis added.)[47] (Emphasis added.)

Thus, the appraised value using the income approach does not depend upon, or relate to, any valuation of the individual depreciable assets, but rather is a valuation of the business enterprise as a whole. Furthermore, when the witness was questioned if the projected earnings utilized in the income method, which is discounted back to a specific point in time, could change over time, the witness responded, "Yes …"[48] Likewise, when questioned whether income could be distorted by free care offered by a non-profit entity as opposed to a for profit entity, the witness responded "it's possible."[49] Consequently, in sum, the Administrator finds that the income approach used by Valuation Counselors to value the business enterprise as a whole based on the projected stream of income is not appropriate for purposes of determining the fair market value of the individual depreciable assets.

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[46] Tr. At 70.

[47] Provider Exhibit P-35 p. 15. The appraisal goes on to explain that: "The income technique uses a Discounted Cash Flow analysis to estimate the value of the business enterprise. This approach is based on the premise that the value of an investment is the present worth of the expected future benefits which accrued to the owners of that investment. In a business valuation, these future benefits are comprised of the net discretionary cash flow … generated by the business. P-35 at 103.

[48] Tr. at 65. Indeed, the Board minutes for the new Jeanes shows that the general revenue stream consistently and notably exceeded expectations even in the year that immediately followed the merger.

[49] Tr. At 66.

The Administrator finds that if one accepts the use of the appraisal, conducted after the merger, the cost approach[50] shows $48,808,000 as the appraised fair market value of the depreciable assets and land, while the financial statements show other current assets valued at approximately $54,595,000,[51] resulting in a total fair market value of the Provider's assets of $103,403,000.[52] When compared with the liabilities assumed and one million paid to the Foundation, which totals $69,214,000, the Administrator concludes that the Provider did not receive reasonable consideration for the assets transferred. As stated above, "a large disparity between the sale price (consideration) and the fair market value of the

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[50] The Provider's expert argued that a factor should have been applied to the cost approach that would have significantly reduced the cost approach closer to the income approach ($30 million), at another point he suggests $39 million) (Tr. 83) because of the difficult economic environment. However, among other things, the application of an economic obsolescence reduction to the cost approach would be dependent upon components of external obsolescence which may be cyclical and, hence, not accurate. Estimates in the loss in value due to external forces are also difficult to project and more subjective than other deductions under the cost approach. Moreover, such a claim that the application of such a factor would have reduced the appraised value by 40-50 percent, is also called into question by the Provider's other witness discussing the application of FASB Statement No. 121. FASB 121 requires a permanent impairment to be written-down when measured by the undiscounted expected future cash flow against the carrying amount of the assets. FASB 121 identifies, inter alia, significant decrease in the market value of an asset; a significant change in the extent or manner in which an asset is used, or a significant physical change in an asset; a significant change in the legislation or business climate that could affect the value of an asset or costs that significantly exceed the amount originally budgeted to acquire or construct an asset. In this instance, the witness acknowledged that the projection of cash flows, immediately after the merger did not require the write down or recording of an impairment of the assets. Tr.128. While economic obsolescence and permanent impairments are different measures, used for different purposes, both to some extent are measures of the market forces. In this instance, the fact that the depreciable assets did not meet the criteria for a permanent impairment after the merger would seem to contradict the need for a significant adjustment suggested by the expert for the alleged economic obsolescence of the assets due to market conditions.

[51] It is not clear whether the Medicare accounts receivables includes the amount of the loss claimed in this case, or whether that would be an additional amount received by the buyer beyond the current assets calculation, if the Provider is successful in this case.

[52] A.R. 116.

assets sold indicates the lack of a *bona fide* sale." In this instance, the transfer price was 66 percent of the fair market value of the assets.[53]

In sum, the Administrator finds that the Provider is not entitled to reimbursement for a loss on a sale because the Provider failed to demonstrate that the merger was a bona fide sale. The Intermediary's adjustment is affirmed.[54]

[53] Finally as a result of the merger, the transaction was treated as a "pooling of interest" Tr. 129. The pooling of interest method results in no revaluation of assets or recording of gains or loses because the combination is accomplished without disbursing resources and the ownership continues. Consistent with the accounting treatment, the Provider's witness acknowledged it was a "loss on paper," only. Tr. 112.

[54] The Administrator also incorporates, by reference the Administrator decision in Adm. Dec. 2003-D62 (November 25, 2003), with respect to the applicable law and fact finding on the issue remanded by the court. The court has already ruled on the related party issue and, therefore, consistent with the remand order, the Administrator does not address that issue in this decision.

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