PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
99-D7

PROVIDER -St. Charles General Hospital
New Orleans, Louisiana

Provider No. 19-0158

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING-
October 7, 1998

Cost Reporting Periods Ended -
May 31, 1991 and May 31, 1992

CASE NOS. 94-1896 & 95-1021

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ISSUE:

Was the Provider entitled to be reimbursed for costs incurred in connection with an abandoned hospital expansion project?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Charles General Hospital ("Provider") is a 163 bed acute care facility located in New Orleans, Louisiana.[1] It is owned by Tenet Healthcare Corporation, previously known as NME Hospitals, Inc.[2]

In the early 1980s the Provider undertook a major expansion project which included plans to construct a new four-story building as an addition to its existing facility. The purpose of the project was to increase the Provider's existing bed capacity; expand, renovate, relocate and consolidate the Provider's ancillary services; expand and remodel its intensive care unit; and, increase the number of operating room suites and to enlarge them to comply with then-current standards.[3] To facilitate this project the Provider entered into a ground lease to acquire land for the building and incurred various expenses including planning costs and construction costs.

During its fiscal year ended May 31, 1991, the Provider decided that the entire project could not be completed due to a decrease in its patient occupancy levels. The Provider then canceled the aforementioned ground lease which required that it pay the lessor a $55,000 termination payment.[4]

Later, during its fiscal year ended May 31, 1992, the Provider chose to terminate the remainder of the project. By this time, the Provider had incurred $1,281,946 in planning costs and $4,019,841 in construction costs in addition to the ground lease settlement.[5] The Provider's planning costs, also described as "soft costs," included expenses such as salaries and wages, consulting costs and advertising expenses.[6] The Provider's construction costs,

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1 Intermediary's Supplemental Position Paper at 3.

2 Provider's Position Paper at 3.

3 Provider's Supplemental Position Paper at 1.

4 Provider's Position Paper at 3.

5 Id.

6 See Intermediary's Supplemental Position Paper at 14.

also described as "hard costs," included work actually completed on the four-story building, interest, and property taxes, etc.[7]

The Provider classified all of the costs associated with the terminated expansion project as capital-related costs. The Provider charged the $55,000 land settlement cost as a capital expense in its fiscal year 1991 Medicare cost report, and charged the remaining $5,301,787 in hard and soft costs as capital expenses in its fiscal year 1992 cost report.

Ætna Life Insurance Company ("Intermediary")[8] reviewed the Provider's cost reports and disallowed the land settlement expense claimed in the 1991 cost report. In addition, the Intermediary disallowed the construction costs claimed in the 1992 cost report, and reclassified the planning costs from a capital-related expense to an operating expense.[9]

On August 31, 1993, the Intermediary issued a Notice of Program Reimbursement ("NPR") for the Provider's 1991 cost report, which reflected its disallowance of the land settlement payment. On September 12, 1994, the Intermediary issued an NPR for the Provider's 1992 cost report, which reflected the disallowed construction costs and the reclassified planning costs. On February 24, 1994, and on February 14, 1995, respectively, the Provider appealed the Intermediary's adjustments to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R.
§§ 405.1835-.1841, and met the jurisdictional requirements of those regulations. The amount of Medicare reimbursement in controversy is approximately $27,000 for the Provider's 1991 cost reporting period and approximately $2,800,000 for 1992.[10]

The Provider was represented by Julia E. Schollenberger, Esq. of Hooper, Lundy & Bookman, Inc. The Intermediary was represented by Marshall Treat, Senior Appeals Consultant, Mutual of Omaha Insurance Company.

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7 See Intermediary's Supplemental Position Paper at 5.

8 Ætna Life Insurance Company issued the Notices of Program Reimbursement at issue in this case, and submitted a Position Paper to brief the issues. Subsequently, the Provider was transferred to Mutual of Omaha Insurance Company, the current intermediary, which submitted a Supplemental Position Paper.

9 Provider's Supplemental Position Paper at 3.

10 Provider's Position Paper at 1-2.

Lease Termination Payment

PROVIDER'S CONTENTIONS:

The Provider contends that the lease termination payment it was required to make is an allowable capital-related cost. The Provider asserts there is no dispute over the fact that this payment was a direct result of its decision to abandon the subject capital project. The property to be leased was to be used solely for the purpose of the Provider's expansion. When the project was terminated, the Provider was forced to cancel the lease and pay the settlement sum of $55,000. The Provider asserts that it acted reasonably.[11]

The Provider contends there is no reason to distinguish the lease termination cost from the abandoned planning costs which have been allowed by the program. If costs incurred in planning a project which is ultimately terminated are allowable, the costs incurred in abandoning a lease which was intended for the same project must similarly be allowed.

The Provider contends that for the same reasons discussed below regarding the planning costs and construction costs at issue in this case, the lease termination cost must be considered an allowable capital-related cost. Each of these categories of costs was incurred as part of a capital project and are part of the costs incurred in abandoning or disposing of the project.

The Provider also contends that the lease termination payment is a capital-related cost pursuant to 42 C.F.R. § 413.130(a)(3), which explains that leases and rentals for the use of a planned project are a capital-related cost. The Provider asserts, therefore, that the sole basis for the Intermediary's adjustment is inaccurate. In its Supplemental Position Paper the Intermediary states that: "[w]hen land is owned, it is capitalized and is not depreciated and not included in allowable costs. . . ." However, lease payments made in connection with a lease of land is an allowable capital-related cost as reflected in 42 C.F.R. § 413.130(a)(3) and (b).

INTERMEDIARY'S CONTENTIONS:

The Intermediary agrees that the Provider's expansion project required that it acquire additional land. Moreover, as part of the abandonment of the project, the Provider agreed to discontinue the aforementioned lease by making a termination payment of $55,000.[12] The Intermediary contends, however, that this payment is part of an investment loss rather than abandoned planning costs. According to Medicare's Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 2154.1, planning costs include such things as feasibility studies,

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[11] Provider's Supplemental Position Paper at 20-21.

[12] Exhibit I-1.

engineering studies, architect fees, and finder's fees. When land is owned, it is capitalized and not depreciated and not included in allowable costs as defined by HCFA Pub. 15-1 §104.6.[13]

Planning Costs

PROVIDER'S CONTENTIONS:

The Provider contends that the planning costs at issue in this case are, in fact, capital-related costs rather than administrative and general expenses as argued by the Intermediary. In accordance with 42 C.F.R § 413.130(a)(1), the subject planning costs represent "losses realized from the disposal of depreciable assets under 42 C.F.R. § 413.134(f)," notwithstanding the fact that the project was abandoned and did not result in a tangible asset.[14]

Medicare regulations at 42 C.F.R. § 413.130(a) state:

> (a) *General Rule.* Capital-related costs and an allowance for return on equity are limited to the following:
>
> > (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) . . .

42 C.F.R. § 413.130(a) (emphasis added).

Respectively, the Provider asserts that the soft costs at issue were incurred in connection with the construction of additions and renovations to its physical plant. These additions and renovations would have been depreciable assets if completed. Moreover, the planning costs were recorded in the Provider's books as a capital asset to be depreciated when the project was completed. The planning costs asset was disposed of when the project was abandoned, and the Provider realized a loss upon the disposal equal to the amount of the planning costs incurred. The planning costs, therefore, are a loss resulting from the disposal of a depreciable asset under 42 C.F.R.
§ 413.134(f), which is a capital-related cost under 42 C.F.R. § 413.130(a)(1), quoted above.

The Provider asserts that in order for a loss to be treated as a capital-related cost under 42 C.F.R. § 413.130(a)(1), two elements must be satisfied: (1) a "disposal" must have occurred, and (2) the disposal must have been of a "depreciable asset." With respect to the first element, 42 C.F.R.

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[13] Intermediary's Supplemental Position Paper at 10.

[14] Provider's Supplemental Position Paper at 5.

§ 413.134(f)(1) states that "[d]epreciable assets may be disposed of through sale, scrapping, trade-in, exchange, demolition, abandonment, condemnation, fire, theft, or other casualty. Medicare regulations at 42 C.F.R. § 413.134(f)(5) defines "abandonment" as:

> the permanent retirement of an asset for any future purpose, not merely the provider ceasing to use the asset for patient care purposes. To claim an abandonment under the Medicare program, the provider must have relinquished all rights, title, claim, and possession of the asset with the intention of never reclaiming it or resuming its ownership, possession, or enjoyment.

42 C.F.R. § 413.134 (f)(5).

The Provider argues that when it decided to discontinue construction of the project, the project costs were retired permanently and completely, which included a relinquishment of all rights, title, claim or possession of the planning costs asset forever. Thus, the Provider asserts that it undeniably "abandoned" the planning costs asset thereby satisfying the first element of 42 C.F.R. § 413.130(a)(1).

The second element requires that the disposal be of a "depreciable asset." The Provider asserts that "depreciable assets" are defined at HCFA Pub. 15-1 § 104.1 as assets "that a provider has an economic interest in through ownership (regardless of the manner in which they are acquired) [which] are subject to depreciation." With respect to this element, the Provider argues that the planning costs at issue were incurred as "construction-in-progress" costs for the project, and represent the first step in construction. Therefore, prior to the abandonment of the project, the planning costs were a capital asset to be depreciated once the project was completed; that is, they were "subject to depreciation."

The Provider adds that it treated the planning costs as a capital asset in its books and records, and clearly intended to begin depreciating these costs once the project was completed. Accordingly, the Provider concludes that the subject planning costs represented a "depreciable asset" as required by the regulation, prior to the abandonment.

The Provider contends that the planning costs at issue are capital-related costs even though the actual construction was not completed.[15] The Administrator of the Health Care Financing Administration ("HCFA") has contended that abandoned planning costs are not a depreciable asset because no tangible asset is formed to which these costs could attach, and that hospitals therefore do not realize a loss on disposal of a depreciable asset when a project is abandoned. However, this conclusion is incorrect.

The Provider asserts that whether planning costs are tangible or intangible assets should not affect whether or not such costs (prior to the abandonment of the related project) are a

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[15] Provider's Supplemental Position Paper at 8.

depreciable asset. Nothing in the regulations limits the recognition of losses on disposal to tangible assets. Rather, the regulations refer to “depreciable assets,” which includes both tangible and intangible assets under the Medicare program.

The Medicare regulation which addresses the recognition of depreciation is 42 C.F.R. § 413.134. This regulation provides that an allowance for depreciation on “buildings and equipment used in the provision of patient care is an allowable cost.” As discussed below, the Medicare regulations and manual provisions reflect that the phrase "buildings and equipment" on which depreciation is allowed is to be construed broadly to include virtually all identifiable assets that are distinct from goodwill. This would include the subject planning costs which are an identifiable asset distinct from goodwill, prior to abandonment of the project.

Specifically, 42 C.F.R. § 413.134(a) must be read in conjunction with 42 C.F.R. § 413.134(g), which sets forth the guidelines for the establishment of the "cost basis" of a facility purchased as an ongoing operation. This cost basis is used for depreciation by the new provider after the purchase.

At 42 C.F.R. § 413.134(g), the regulation does not distinguish between tangible and intangible assets. Rather, that regulation requires that a cost basis include all "individual assets" or all "individually identified assets." 42 C.F.R. §§ 413.134(g)(1), (2), and (3).

Prior to 1979, 20 C.F.R. § 405.415(g), the predecessor to 42 C.F.R. § 413.134(g),[16] may have limited the cost basis of a facility to the fair market value of the facility's tangible assets through an explicit reference to "tangible assets." Prior to 1979, 20 C.F.R. § 405.415(g) provided:

> where a facility is purchased as an ongoing operation on or after [August 1, 1970], the cost basis shall not exceed the fair market value of the tangible assets purchased, subject to the above limitations applicable to depreciable assets.

20 C.F.R. 405.415(g) (emphasis added).

Effective February 5, 1979, however, 42 C.F.R. § 405.415(g) was modified to limit the cost basis to the fair market value of the facility's "individually identified assets," rather than the tangible assets being acquired.[17] The amendment clearly reflects that the phrase "individually identified assets" means something other than, and is not restricted to, "tangible assets."

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[16] 20 C.F.R. § 405.415 was recodified as 42 C.F.R. § 405.415 in 1977. 42 Fed. Reg. 52826 (Sept. 30, 1977). 42 C.F.R. § 405.415 was redesignated as 42 C.F.R. § 413.134 in 1986. 52 Fed. Reg. 34790 (Sept. 30, 1986).

[17] See, 44 Fed. Reg. 6912 (Feb. 5, 1979)

Accordingly, in order for the reference to "buildings and equipment" in 42 C.F.R. § 413.134(a) to be in harmony with 42 C.F.R. § 413.134(g), it must be broadly interpreted to include all identifiable assets regardless of whether such assets are tangible or intangible. Moreover, this appears to be the interpretation that has been given to 42 C.F.R. § 413.130(a) in several manual provisions.

For example, pursuant to HCFA Pub. 15-1 § 104.17, computer software may be depreciated even though it is intangible. Similarly, pursuant to HCFA Pub. 15-1 § 111, amounts paid by a provider for a favorable lease may be depreciated even though a favorable lease is an intangible asset.

Significantly, HCFA Pub. 15-1 §§ 104.17 and 111 are in the chapter of the manual which addresses depreciation and which purports to interpret 42 C.F.R. § 413.134. Thus, HCFA has construed "buildings and equipment" expansively, and in a manner which is not limited to tangible assets, but includes all identifiable assets apart from goodwill. See Villa View Community Hospital, Inc. v. Heckler, 720 F.2d 1086, 1093-1094 (9th Cir. 1983), in which the Court treated a hospital's "land use rights" as a depreciable asset, and rejected the argument that the phrase "buildings and equipment" did not encompass this asset.

Further, the manual provisions addressing planning costs demonstrate that planning costs are a depreciable asset. Pursuant to HCFA Pub. 15-1 §§ 2154.1 and 2154.4, planning costs are capitalized and depreciated over the useful life of the facilities to which they relate. See also Spartenburg General Hospital v. Heckler, 607 F. Supp. 636, 640 n.5 (D.S.C. 1985) in which the court notes that the indirect capital costs which may be capitalized under Medicare include planning costs, legal fees, interest costs on construction loans, advertising costs and start-up costs.

Thus, the Provider asserts that it is apparent from the manual provisions that planning costs must be capitalized. This necessarily means that such costs are treated as an asset. If the project to which the planning costs relate is completed, the planning costs are depreciated over the useful life of the project. If the project is not completed, the planning costs are recognized immediately because the planning costs are of no continuing use to the provider. Essentially, planning costs are treated the same as any other depreciable asset.

The Provider contends that even if the planning costs at issue in this case are found not to be a loss realized from the disposal of a depreciable asset, they still qualify as capital-related because they constitute a cost of "betterments and improvements" pursuant to 42 C.F.R. § 413.130(a)(4).[18]

"Betterments and improvements" are defined as "changes which extend the estimated useful life of an asset at least two years beyond its original estimated useful life, or increase the

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[18] Provider's Supplemental Position Paper at 11.

productivity of an asset significantly over its original productivity." 42 C. F. R. § 413.130(c)(1). Medicare instructions at HCFA Pub. 15-1 § 2154 state: "[w] hen a provider plans for any physical plant construction or plans to purchase an existing facility or land to expand, rebuild or relocate its present facility, it generally incurs planning costs." (Emphasis added). Further, the manual defines "expand" as: "[t]o increase the size of a provider's facility. . ." Id. With respect to the instant case, the costs at issue were incurred as planning costs for a project which would have "expanded" the existing hospital facility in accordance with HCFA Pub. 15-1 § 2154.2. Since the project would expand the existing hospital facility, it would necessarily increase the productivity of the facility in satisfaction of the definition of "betterments and improvements" found at 42 C.F.R. §§ 413.130(a)(4) and 413.130(c).

The Provider also contends that planning costs are not included in the description of non-capital-related costs.[19] Regulations at 42 C.F.R. § 413.130(I) identify "costs [specifically] excluded from capital-related costs," as follows:

> (1) Costs incurred for the repair or maintenance of equipment or facilities.
>
> (2) Amounts included in rentals or lease payment for repair or maintenance agreements.
>
> (3) Interest expense incurred to borrow working capital (for operating expenses).
>
> (4) General liability insurance or any other form of insurance to provide protection other than for the replacement of depreciable assets or to pay capital-related costs in the case of business interruption.
>
> (5) Taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care. . . .
>
> (6) The costs of minor equipment that are charged off to expense rather than capitalized as described in paragraph (d) of this section.
>
> (7) The costs incurred for maintenance and repair insurance agreements. . .

42 C.F.R. § 413.130(I).

The Provider asserts that planning costs are clearly more similar to the costs listed in 42 C.F.R.
§ 413.130(a) than the costs listed in 42 C.F.R. § 413.130(I), because they relate to a hospital's long-term capital projects rather than day-to-day operations.

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[19] Provider's Supplemental Position Paper at 12.

The Provider contends that an interpretation of the regulations which treats planning costs as operating expenses is inconsistent with the enabling statute.[20] The pertinent statute, 42 U.S.C. § 1395ww(a)(4), provides that, for cost reporting periods beginning on or after October 1, 1983, "capital-related costs will be excluded from a hospital's Part A inpatient costs (for which payment will be made prospectively on a per discharge basis) and will be reimbursed on a retrospective reasonable cost basis." The statute excludes not only "capital costs" from a hospital's Part A inpatient costs reimbursed on a prospective per discharge basis, but also "capital-related costs." Id.

With respect to this matter, the Provider asserts that a statute must be interpreted using the common meaning of the statutory language. Perrin v. United States, 444 U.S. 37, 42 (1979). Moreover, the word "related" has been defined as "standing in relation; connected; allied or akin." Nowland Realty Co. v. Commission of Internal Revenue, 47 F.2d 1018, 1021 (7th Cir. 1931); see also Black's Law Dictionary (5th Ed. 1979); Webster's Collegiate Dictionary (10th Ed. 1996) ("connected by reason of an established or discoverable relation"). Therefore, using the plain meaning of the applicable statutory language, the planning costs at issue in this case are capital-related costs since they are connected to, stand in relation to and are allied with a proposed capital project.

The Provider also contends that the statute fails to distinguish between costs of completed projects and costs of projects that are not completed. The Provider cites four decisions where the Board found that a cost is determined to be capital-related based upon the nature of the cost at the time it is incurred.[21] Where a cost is incurred in connection with a capital project,

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[20] Provider's Supplemental Position Paper at 13.

[21] Grossmont Hospital District La Mesa, CA v. Ætna Life Insurance Company, PRRB Dec. No. 92-D3, Jan. 15, 1992, Medicare & Medicaid Guide (CCH) ¶ 39,808; Mary Hitchcock Memorial Hospital v. Blue Cross and Blue Shield Associated/Blue Cross and Blue Shield of New Hampshire-Vermont, PRRB Dec. No. 91-D56, July 16, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,488; Mercy Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Florida, Inc., PRRB Dec. No. 91-D37, April 3, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,147; Fayette Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Indiana, PRRB Dec. No. 90-D38, June 26, 1990, Medicare & Medicaid Guide (CCH) ¶ 38,598. But see Methodist Hospital of Sacramento v. Sullivan, PRRB Dec. No. 89-D25, March 3, 1989, Medicare & Medicaid Guide (CCH) ¶ 37,677 (ER at 83-88), aff d, Methodist Hosp. of Sacramento v. Sullivan, E.D. Cal., No. S-89-0643 MLS, February 27, 1990, Medicare & Medicaid Guide (CCH) ¶ 38,512. These Board decisions were, however, subsequently reversed: Grossmont Hospital was reversed by the Administrator, and the Administrator was upheld by the United States District Court for the District of Columbia, 826 F.Supp. 1 (D.D.C. 1993); Mary Hitchcock was overturned by the Administrator, Medicare & Medicaid Guide (CCH) ¶ 39,587, and

the character of the cost from the outset is capital-related, and the character of the cost does not change simply because the project is not completed and the cost is written off.

The Provider asserts that although the Board decisions were overturned by the HCFA Administrator, and that the Administrator's decisions were upheld by courts in both cases in which the provider sought federal review, the Provider submits that the Board's decisions in the prior cases are better reasoned than the Administrator's or the Courts'. It is uncontroverted that the purpose of the hospital incurring the subject planning costs was the construction of a capital project which would have increased bed capacity and housed ancillary services. This is clearly a capital project not related at all to the day-to-day operations of the facility.

The Provider contends that an interpretation of the governing regulation, 42 C.F.R. § 413.130(a)(1), as requiring a capital project to be completed before the status of the associated planning costs can be determined would be arbitrary and capricious.[22] Such an interpretation is plainly erroneous and is based on an irrational distinction between costs associated with projects which are completed and costs associated with projects that are abandoned. Further, regardless of whether the associated project is completed, planning costs are in no way incurred as operating costs at any stage of the construction, but instead have the nature of capital-related costs from the outset.

As reflected in the prior Board decisions (see e.g., supra, footnote 21), a provider determines whether planning costs are a capital asset or should be treated as a routine operating expense when the costs are incurred. This allows a provider to know from the outset how the costs are to be treated. A distinction between a completed project and an abandoned project, however, would unreasonably require that a provider wait until a project is either completed or abandoned to determine the status of the related planning costs. This approach, in addition to being inconsistent with the accounting treatment of planning costs by providers, would severely hinder a hospital's ability to engage in financial planning. The hospital, at the time of incurring the planning costs, would not be able to predict whether the Medicare program

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the Administrator's decision was subsequently upheld by the United States District Court for the District of New Hampshire, Medicare & Medicaid Guide (CCH) ¶ 40,956; and Mercy Hospital was also overturned by the Administrator, Medicare & Medicaid Guide (CCH) ¶ 39,245, and the Administrator was upheld by the District Court for the District of Columbia, Medicare & Medicaid Guide (CCH) ¶ 41,456. Fayette Memorial Hospital was reversed by the Administrator, Medicare & Medicaid Guide (CCH) ¶ 38,662, but was not challenged in the district court. Neither the Board, Administrator, nor prior court decisions constitute binding precedent; they are significant to the extent the Board finds their reasoning persuasive.

[22] Provider's Supplemental Position Paper at 15.

would reimburse any portion of such costs.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its reclassification of the subject planning costs from capital-related costs to administrative and general expenses is correct.[23]

The Intermediary contends that the planning costs are an allowable program expense in accordance with HCFA Pub. 15-1 § 2154.4, which states in part:

> [i]f a provider abandons its plans to construct or purchase a facility, the cost of such plans is allowable if the planning was for the purpose of expanding, rebuilding, or relocating the operations of the certified facility.

HCFA Pub. 15-1 § 2154.4.

However, the planning costs must be treated as operating expenses because they are not associated with a capital-related cost. That is, the planning costs at issue in this case are, in fact, associated with an abandonment of construction-in progress. And, as discussed below, abandonment of construction-in-progress results in an investment loss rather than the disposal of a depreciable asset. HCFA Pub. 15-1 § 2155. The Intermediary asserts there is no basis upon which to consider the subject planning costs as capital-related.

In support of its position, the Intermediary cites Methodist Hospital of Sacramento v. Sullivan No. S-89-0643 MLS, February 27, 1990. In this case, the U.S. District Court for the Eastern District of California found that planning costs should be classified in administrative and general expenses because they could not be attached to any capital-related costs for amortization due to abandonment of expansion plans.

Construction Costs

PROVIDER'S CONTENTIONS:

The Provider contends that the construction costs incurred as part of its expansion project are allowable capital-related costs.[24]

The Provider contends that the Intermediary's application of HCFA Pub. 15-1 § 2155 as the basis for its disallowance is improper. The manual states:

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[23] Intermediary's Supplemental Position Paper at 14.

[24] Provider's Supplemental Position Paper at 16.

> [w]here a Provider begins construction of a new facility to expand, rebuild, or relocate its present certified facility and then later abandons the partially completed asset, the cost of this abandoned asset, excluding planning costs described in
> §§ 2154ff, is an investment loss and is not allowable under the Medicare program. If a provider abandons a partially constructed asset which would have become a new certified facility, the loss, including abandoned planning costs, is not allowable.

HCFA Pub. 15-1 § 2155.

With respect to the Intermediary's misapplication of the manual instructions, the Provider argues that HCFA Pub. 15-1 § 2155 is apparently intended to cover only situations in which a provider incurred construction-in-progress costs for the purpose of creating a facility which would become a newly certified provider. This conclusion is supported by the introductory clause of the manual section which refers to the construction of a "new facility." With respect to the instant case, the Provider's expansion project was to be completed and operated under its existing certification. Thus, it appears that HCFA Pub. 15-1 § 2155 is inapplicable.

The Provider also argues that application of HCFA Pub. 15-1 § 2155 to the instant case is wholly arbitrary. It cannot be disputed that the Provider's decision first to commence its expansion project, and later to abandon that project, was reasonable. This was reflected by the Intermediary's determination that the Provider's planning costs are allowable. The Intermediary may allow such costs only if they were incurred reasonably. HCFA Pub. 15-1 § 2154.4. Accordingly, since the subject construction costs were incurred in a reasonable fashion, and relate to the Provider's existing facility certification, the costs must be allowed.

The Provider also contends that there is no rational basis for distinguishing between planning costs and structuring costs of abandoned projects related to a provider's existing certification. Planning costs incurred prior to the construction of an expansion project are allowable. When the project is abandoned it necessarily follows that the construction costs associated with implementing the planning must also be allowed if the project is abandoned. By finding abandoned planning costs as allowable costs, the Medicare program has necessarily determined that such costs are "necessary and proper costs" in accordance with 42 C.F.R. § 413.9(b). That regulation defines reasonable costs to include all necessary and proper costs. Necessary and proper costs, in turn, "are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. 42 C.F.R. §413.9(b)(2). Therefore, if costs of planning a project which is ultimately abandoned are considered appropriate and helpful in developing and maintaining the operation of patient care facilities and activities, the costs of constructing a project which is ultimately abandoned must similarly be considered appropriate and helpful in developing and maintaining a provider's patient care facilities.

In addition, the manual provisions pertaining to abandoned planning costs recognize that it is reasonable for a provider to begin a project which is ultimately abandoned. The provisions assert that these are normal costs incurred by providers and, as such, are related to the provider's existing facility and are related to patient care. In effect, the manual reflects the program's determination that providers should not be penalized for reasonable decisions made to commence and later abandon projects. If the program did not allow abandon planning costs where a provider acted reasonably, providers would be encouraged to continue with projects that turn out to be unwise or unnecessary in order to ensure that the planning costs will be reimbursed. Accordingly, similar considerations must apply to construction costs incurred by providers. Just like planning costs, it is reasonable and common for providers to incur construction costs in connection with projects which are ultimately abandoned. It is also reasonable to allow such costs to avoid providing a disincentive to providers to terminate projects that ultimately prove to be unnecessary.

In all, the Provider argues that there is no rational basis to distinguish planning costs and construction costs associated with projects which are ultimately abandoned. Since, in the instant case, the Provider acted reasonably when incurring the construction costs at issue, such costs must be allowed.

Notwithstanding, the Provider contends that the Intermediary's reliance upon HCFA Pub. 15-1
§ 2155 should not be given credence for two additional reasons. First, the Intermediary did not cite HCFA Pub. 15-1 § 2155 in its work papers to support its adjustment (See Exhibit I-4), or in its initial Position Paper. Second, if the Intermediary were to apply HCFA Pub. 15-1 § 2155, it would have to treat the construction costs as an "investment loss" and reduce investment income appropriately. However, no reduction to investment income was made for the amount of the construction costs.[25]

Finally, the Provider contends that the construction costs at issue in this case must be treated as capital-related costs for the same reasons that the planning costs must be treated as capital-related costs, as discussed above.[26] Once the project was abandoned, the construction costs were part of the Provider's construction-in-process asset along with the Provider's planning costs. The loss or disposal of such an asset is specifically recognized as a capital-related cost under the Medicare regulations. 42 C.F.R. §413.130(a)(1).

As with the planning costs, construction costs are not analogous to any of the costs that are excluded from the definition of capital-related costs under Medicare regulations 42.C.F.R. §413.130(I). Unlike the excluded costs, the costs at issue are not normal costs of the Provider's day-to-day operations.

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[25] Provider's Supplemental Position Paper at 19 at Footnote 5.

[26] Provider's Supplemental Position Paper at 19.

Moreover, construction costs are also capital-related pursuant to the plain meaning of that term as used in the pertinent statue, since the construction costs were clearly incurred in relation to a
capital project. And finally, as with the planning costs, there is simply no reason to distinguish between construction costs incurred with respect to projects which are completed and construction costs incurred with respect to projects which are not completed, in determining whether to treat such costs as capital-related costs or operating expenditures.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment disallowing the Provider's construction costs is proper. The Intermediary asserts that the Provider's argument that construction-in-progress is a depreciable asset is incorrect.[27]

The Intermediary contends that construction-in-progress costs are simply accumulated, capitalized, and allowed through amortization as depreciation once an asset is ready for patient care use. With respect to the instant case, the Provider abandoned its expansion project before it was eligible and applicable to patient care. In this circumstance, the total costs of the project including planing costs represent investment losses realized from the abandonment. The specific reference for this reimbursement principle is HCFA Pub. 15-1 § 2155, titled Abandonment of Construction-In-Progress. In part, the manual states:

> [w]here a provider begins construction of a new facility to expand, rebuild or - relocate its present certified facility and then later abandons the partially completed asset, the cost of this abandoned asset, excluding planning costs described in Section 2154, is an investment loss and is not allowable under the Medicare program. If a provider abandons a partially constructed asset which would have become a newly certified facility, the loss, including planning costs, is not allowable.

HCFA Pub. 15-1 § 2155.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost
§ 1395ww(a)(4)	-	Limits on Operating Costs for Inpatient Hospital Services

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[27] Intermediary's Supplemental Position Paper at 5.

2. Regulations - 42 C.F.R.:

§ 405.1835-.1841	-	Board Jurisdiction
§ 413.9(b)(2)	-	Cost Related to Patient Care-Necessary and Proper Costs
§ 413.130(a)	-	General Rule. Capital-Related Costs
§ 413.130(b)	-	Leases and Rentals
§ 413.130(c)	-	Betterments and Improvements
§ 413.130(I)	-	Costs Excluded From Capital-Related Costs
§ 413.134 (Previously 42 C.F.R. § 405.415)	-	Depreciation
§ 413.134(f)	-	Gains and Losses on Disposal of Depreciable Assets
§ 413.134(f)(5)	-	Demolition or Abandonment
§ 413.134(g)	-	Establishment of Cost Basis on Purchase of Facility as an Ongoing Operation

3. Program Instructions-Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 104.1	-	Depreciable Assets
§ 104.6	-	Land (Non-Depreciable)
§ 104.17	-	Useful Life of Depreciable Assets
§ 111	-	Assumption of Lease at Less Than Fair Rental Value
§ 2154	-	Planning Costs
§ 2154.1	-	Planning Costs-General

§ 2154.2	-	Definitions
§ 2154.4	-	Planning Costs Where Plans are Abandoned
§ 2155	-	Abandonment of Construction-In-Progress

4. Case Law:

Villa View Community Hospital, Inc. v. Heckler, 720 F.2d 1086 (9th Cir. 1983).

Spartenburg General Hospital v. Heckler, 607 F. Supp. 636 (D.S.C. 1985).

Perrin v. United States, 444 U.S. 37 (1979).

Nowland Realty Co. v. Commission of Internal Revenue, 47 F.2d 1018 (7th Cir. 1931).

Granada Hills Community Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 96-D12, May 9, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,674, decl'd. rev. HCFA Admin. June 14, 1996.

Grossmont Hospital District v. Ætna Life Insurance Company, PRRB Dec. No. 92-D3, January 15, 1992, Medicare & Medicaid Guide (CCH) ¶ 39,808, rev'd. HCFA Admin., March 3, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,715, aff'd. Grossmont Hospital Corp. v. Sullivan, 826 F.Supp. 1 (D.D.C. 1993).

Mary Hitchcock Memorial Hospital v. Blue Cross and Blue Shield Associated/Blue Cross and Blue Shield of New Hampshire-Vermont, PRRB Dec. No. 91-D56, July 16, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,488, rev'd., HCFA Admin., Sept. 11, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,587, affm'd. Mary Hitchcock Memorial Hospital v. Sullivan CV91-666M (D.N.H. Nov. 30, 1992).

Mercy Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Florida, Inc., PRRB Dec. No. 91-D37, April 3, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,147, rev'd. HCFA Admin., May 30, 1991, Medicare & Medicaid Guide (CCH)
¶ 39,245, affm'd. Mercy Hospital v. Sullivan, 823 F. Supp. 1 (D.D.C. 1993).

Fayette Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Indiana, PRRB Dec. No. 90-D38, June 26, 1990, Medicare & Medicaid

Guide (CCH) ¶ 38,598. rev'd. HCFA Admin., Aug. 16, 1990, Medicare & Medicaid Guide (CCH) ¶ 38,662.

Methodist Hospital of Sacramento v. Sullivan, PRRB Dec. No. 89-D25, March 3, 1989, Medicare & Medicaid Guide (CCH) ¶ 37,677, decl'd rev. HCFA Admin. April 17, 1989, aff'd. Methodist Hospital of Sacramento v. Sullivan, E.D. Cal., No. S-89-0643 MLS, February 27, 1990 ("Methodist Hospital").

5. Other:

Black's Law Dictionary (5th Ed. 1979).

Webster's Collegiate Dictionary (10th Ed. 1996).

44 Fed. Reg. 6912 (Feb. 5, 1979).

42 Fed. Reg. 52826 (Sept. 30, 1977).

52 Fed. Reg. 34790 (Sept. 30, 1986).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

Lease Termination Payment

The Board finds that the payment made by the provider to terminate the lease it had entered to acquire land for its expansion project is neither an allowable capital-related cost nor an allowable operating cost. Regulations at 42 C.F.R. § 413.130(a)(3) and (b) explain that leases qualify as capital-related costs if they relate to the use of assets that would be depreciable if the provider owned them outright. Pursuant to 42 C.F.R. § 413.134(a), an asset must be "used in the provision of patient care" to be depreciable. Respectively, the land at issue in this case was never used in the provision of patient care and, therefore, cannot be treated as a capital-related cost for the purpose of program reimbursement.

The lease termination payment also cannot be treated as an operating cost. The Board finds that the payment was the direct result of a capital project and represents the acquisition of a tangible asset. As such, the Board concludes that the Provider's entrance into the lease and the associated termination payment is necessarily treated the same as construction-in progress costs. Accordingly, the lease termination payment is an investment loss which, as discussed below under Construction Costs, is not an allowable program cost.

The Provider argues that the lease termination payment should not be distinguished from planning costs which it also incurred. However, the Board disagrees. The Board is not persuaded by the Provider's arguments regarding planning costs, discussed immediately below, or the description of planning costs found at HCFA Pub. 15-1 § 2154.1, that the termination payment should not be considered an investment loss.

Planning Costs

The Board finds that the planning costs at issue in this case are an allowable cost. Program instructions at HCFA Pub. 15-1 § 2154.4 explain that if plans to expand, rebuild or relocate a certified facility are abandoned, as in the instant case, the cost of such plans are allowable either in the year of abandonment or over a three year amortization period.

However, contrary to the Provider's arguments, the Board finds that the subject abandoned planning costs are an operating expenditure rather than a capital-related cost. With respect to this matter, the Board agrees with the analyses of prior Boards in Methodist Hospital and, most recently, Granada Hills Community Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 96-D12, May 9, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,674, decl'd rev. HCFA Admin. June 14, 1996.

In particular, the Board finds that 42 C.F.R. § 413.130(a) provides an all-inclusive list of capital-related costs. That is, in order for a cost to be given capital-related cost treatment it must appear on this list. With respect to the instant case, the Board notes that planning costs are not reflected in 42 C.F.R. § 413.130(a) and, therefore, are not capital-related costs.

The Board rejects the Provider's argument that the planning costs at issue are reflected in 42 C.F.R. § 413.130(a)(1) since they represent a loss on the disposal of a depreciable asset. In part, the Provider argues that it recorded the planning costs in its accounting records as capital-related costs at the time they were incurred; the planning costs were incurred in connection with additions and renovations to its physical plant that would have been depreciable if completed; and, the pertinent statute does not distinguish between completed and not-completed projects. See 42 U.S.C. § 1395ww(a)(4).

The Board, however, finds that no depreciable asset was disposed of through the abandonment of the Provider's expansion project. As noted above, in order for an asset to be depreciable under the Medicare program it must be "used in the provision of patient care," 42 C.F.R. § 413.134(a), which is not the circumstance in this case. In principle, the Provider incurred planning costs to expand its facility and began construction of a new building. The planning costs would have become part of the historical cost of this building for the purpose of depreciation once it was completed and put into patient care use. However, the abandonment occurred prior to the building's completion and it was never used for patient care; it never became a depreciable asset. The Board emphasizes that the planning costs at issue would have become part of the historical cost of the building that was abandoned, and

there is no basis upon which to consider these costs part of or associated with any other depreciable asset.

The Board also rejects the Provider's argument that the planning costs at issue are reflected in the list of capital-related costs at 42 C.F.R. § 413.130(a)(4) since they qualify as "betterments and improvements." The Provider argues that the planning costs would have increased the productivity of its facility which is consistent with the definition of betterments and improvements found at 42 C.F.R. § 413.130(c). However, the Board finds the Provider's argument without merit. Regulation 42 C.F.R. § 413.130(c) recognizes betterments and improvements as capital related costs if they reflect changes which actually increase productivity. The regulation does not recognize what would have been, for example, had the Provider's expansion project been completed rather than having been abandoned prior to patient care use.

The Board acknowledges the Provider's argument that planning costs are not reflected in the listing of costs specifically excluded from capital-related costs found at 42 C.F.R. § 413.130(I). However, the Board finds this listing to be a guide to the treatment of certain specific costs rather than an all-inclusive listing for the purpose of determining whether or not a cost is capital-related. Therefore, the Board finds that the Provider's reference to the listing at 42 C.F.R. § 413.130(I) does not support the Provider's case.

Finally, the Board rejects the Provider's argument that treating planning costs as operating expenses is inconsistent with the enabling statute. In general, the Provider argues that 42 U.S.C. 1395ww(a)(4) does not speak in terms limited to "capital costs" but actually speaks in the broader sense to costs "related" to capital. In this scheme of thought, the Provider purports that planning costs should be given capital-related cost treatment since they clearly relate more closely to capital expenditures than they do to day-to-day operating costs. However, as discussed above, the Board finds that 42 C.F.R. § 413.130 is an all-inclusive listing of costs recognized as capital-related under the Medicare program. Moreover, planning costs are not specifically shown on this list nor can they be considered a loss on the disposal of a depreciable asset or a betterment or improvement.

Construction Costs

The Board finds that the Provider began construction of the new building it had planned. Respectively, the Provider began to incur construction costs such as property taxes and interest expense as well as costs of building actual physical structures such as a foundation and elevator shafts. Moreover, the Board finds these costs would have become part of the historical cost of the building for the purpose of program reimbursement once it was completed and put into patient care use. However, the project was abandoned before the building was completed and could be used for patient care.

The Board finds that in this circumstance the construction costs or "abandoned construction-

in-progress" are clearly unallowable. Program instructions at HCFA Pub. 15-1 § 2155 state, in pertinent part:

> [w]here a provider begins construction of a new facility to expand, rebuild or relocate its present certified facility and then later abandons the partially completed asset, the cost of this abandoned asset, excluding planning costs described in Section 2154, is an investment loss and is not allowable under the Medicare program.

HCFA Pub. 15-1 § 2155.

The Board rejects the Provider's argument that HCFA Pub. 15-1 § 2155 pertains only to situations where costs are incurred for the purpose of creating a facility that would become a newly certified provider. The Board finds that the manual instruction is clear and unambiguous, and clearly applies to the expansion of presently certified provider's as in the instant case.

Finally, the Board acknowledges the Provider's contention that abandoned construction-in-progress should not be distinguished from planning costs and should be given capital-related cost treatment based upon the arguments presented for that issue. The Board, however, does not find any of the arguments presented by the Provider regarding planning costs to be persuasive with respect to the capital-related nature of abandoned construction costs. Moreover, the Board finds abandoned construction-in-progress distinctive from planning costs as it did with the Provider's lease termination payment discussed above. Specifically, the purpose of incurring construction costs is to produce a tangible asset that will be used for patient care. Planning costs are not tangible; they are incurred to facilitate the decision making process, for example, to help decide whether or not construction costs should be incurred.

DECISION AND ORDER:

The Intermediary's adjustments disallowing the Provider's lease termination payment and construction costs are proper. The Intermediary's adjustment reclassifying the Provider's planning costs from a capital-related cost to an administrative and general cost in also proper. The Intermediary's adjustments are affirmed.

Board Members Participating:
Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr. Esquire
Charles R. Barker

Date of Decision: November 24, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman