ALABAMA MEDICAID AGENCY
ADMINISTRATIVE CODE

CHAPTER 560-X-22
NURSING FACILITY REIMBURSEMENT

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560-X-22-.01 Nursing Facility Reimbursement - Preface.

This regulation states the Medicaid policy regarding nursing facility reimbursement and establishes the accepted procedures whereby reimbursement is made to nursing facility providers. Because ofthe length and complexity of this chapter, it has been divided into the following sections to facilitate its utilization.
Author: Susan Mims
Statutory Authority: Code of Ala. 1975, §41-22-2.

History: Rule effective October 1, 1982. Amended effective October 1, 1990. **Emergency rule** effective September 12, 1991. Amended effective December 12, 1991.

560-X-22-.02 Introduction.

(1) This chapter of the Alabama Medicaid Regulations has been promulgated by the Alabama Medicaid Agency, Medicaid, for the guidance of providers of Medicaid nursing facility care. This chapter is applicable to those providers categorized as NF, NF/IMD, and NF/IDD. It does not apply to those providers categorized as ICF/MR.

(2) The Alabama Medicaid Program is administered by Medicaid under the direction of the Governor's office. Reimbursement principles for nursing facilities are outlined in the following sections of this chapter. These principles, hereinafter referred to as "Medicaid Reimbursement Principles," are a combination of generally accepted accounting principles, principles included in the State Plan, Medicare (Title XVIII) Principles of Reimbursement, and principles and procedures promulgated by Medicaid to provide reimbursement of provider costs which must be incurred by efficiently and economically operated nursing facilities. These principles are not intended to be all inclusive, and additions, deletions, and changes to them will be made by Medicaid on an annual basis, or as required. Providers are urged to familiarize themselves fully with the following information, as cost reports must be submitted to Medicaid in compliance with this regulation.

(3) If this regulation is silent on a given point, Medicaid will normally rely on Medicare (Title XVIII) Principles of Retrospective Reimbursement and, in the event such Medicare Principles provide no guidance, Medicaid may impose other reasonability tests. The tests include, but are not limited to, such tests as:

(a) Does the cost as reported comply with generally accepted accounting principles?

(b) Is the cost reasonable on its own merit?

(c) How does the cost compare with that submitted by similarly sized homes furnishing like category of care?(d) Is the cost related to patient care and necessary to the operations of a nursing facility?

(4) It is recognized that there are many factors involved in operating a nursing facility. The size of the facility, the intensity of care required, the geographical location (rural or urban), the available labor market, and the availability of

qualified consultants are only examples of such factors, and considerable effort has been made to recognize such variables during the development of this chapter. Only reported costs reflecting such variables without exceeding the "prudent buyer" concept or other applied tests of reasonability will be allowed by Medicaid. Medicaid will consider granting variances from the Medicaid Reimbursement Principles whenever a provider submits convincing evidence that it can provide a service in a more cost effective manner if such variance is permitted. Such evidence should be submitted to Chief Auditor, Provider Audit, for approval.

(5) Records must be kept by the provider which document and justify costs, and only those costs which can be fully and properly substantiated will be allowed by Medicaid. Increases over amounts reported on a provider's previous cost reports, except those increases inherent in normal inflation, will be closely examined for reasonableness.

(6) The principles presented herein are based on the "prudent buyer" concept. Nursing facility administrators are expected to conduct their business in an efficient and conservative manner, and to submit requests for reimbursement only for costs which are absolutely necessary to the conduct of an economically and efficiently operated nursing facility.

(7) Unallowable costs which are identified during either desk audits or field audits will be disallowed despite similar costs having been included in prior cost reports without having been disallowed.

(8) The only source of the funds expended by Medicaid is public funds, exacted from the taxpayers through state and federal taxes. Improper encroachment on these funds is an affront to the taxpayers and will be treated accordingly.

(9) To assure only necessary expenditures of public money, it will be the policy of Medicaid to:

(a) Conduct onsite audits of facilities on an unannounced basis, although prior announcement may be made at the discretion of Medicaid.

(b) Determine audit exceptions in accordance with Medicaid Reimbursement Principles.

(c) Allow only nonextravagant, reasonable, necessary and other allowable costs and demand prompt repayment of any unallowable amounts to Medicaid.

(10) In the event desk audits or field audits by Medicaid's staff reveal that providers persist in including unallowable costs in their cost reports, Medicaid may refer its findings to the

Medicaid Investigation Section, Medicaid Counsel, and/or the Alabama Attorney General.

(11) **CAUTION**: The cost allowances contained in this chapter are maximum allowances, and are not considered a standard. Providers whose costs are normally and historically below the presented amounts may not automatically report the larger amount.

(12) While the responsibility for establishing policies throughout the Medicaid Program rests with Medicaid, comments on the contents of this chapter are invited and will be given full consideration.
Author: Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272.
History: Rule effective October 1, 1982. Amended effective July 9, 1984; October 11, 1986. **Emergency rule** effective May 1, 1988. Amended effective July 12, 1988; October 1, 1990. **Emergency rule** effective September 12, 1991. Amended effective December 12, 1991.

560-X-22-.03 Definitions.

(1) **Accrual Method of Accounting** - Revenues must be allocated to the accounting period in which they are earned and expenses must be charged to the period in which they are incurred. This must be done regardless of when cash is received or disbursed.

(2) **Adjusted Reported Costs** - The net reported costs from Schedule D, Column 7, of the cost report adjusted, as required, for unallowable costs, and cost recovery items.

(3) **Medicaid** - The Alabama Medicaid Agency.

(4) **Medicaid Reimbursement Principles** - A combination of generally accepted accounting principles, principles included in the State Plan, Medicare (Title XVIII) Principles of Reimbursement, and procedures and principles promulgated by Medicaid to provide reimbursement of provider costs which must be incurred by efficiently and economically operated nursing facilities.

(5) **Allowable Costs** - The costs of a provider of nursing facility services which must be incurred by an efficiently and economically operated facility and which are not otherwise disallowed by the reimbursement principles established under and incorporated into this chapter.

(6) **Approved Bed Rate** - The Medicaid rate paid to nursing facilities for approved beds. (See Section 5 for computation.)

(7) **Category** - Grouping formed according to type of facility. Medicaid categories to which this chapter applies are: NF, NF/IMD, and NF/IDD.

(8) **Chapter** - This chapter (560-X-22) of the Alabama Medicaid Administrative Code.

(9) **Cost Recovery Item** - Income generated by an element of allowable cost.

(10) **Facility** - Any structure licensed by the State of Alabama for the purpose of providing long-term care to the aged, ill, or disabled.

(11) **Fair Market Value** - The bona fide price at which an asset would change hands or at which services would be purchased between a willing buyer and a willing seller, neither being under any compulsion to buy or sell and both having reasonable knowledge of the relevant facts.

(12) **Fiscal Year** - The 12 month period upon which providers are required to report their costs, being the period from July 1st through June 30th, also called the "reporting period."

(13) **HCFA** - The Health Care Financing Administration, an agency of the U.S. Department of Health and Human Services.

(14) **HIM-15** - The title of the Medicare Provider Reimbursement Manual, a publication of HCFA. All references to this manual or to Title XVIII Principles of Reimbursement in Chapter 22 are for the "Retrospective" Reasonable Cost Reimbursement Principles and not those of the 10-1-83 Prospective Medicare System.

(15) **Hold Bed Days** - The period during which a provider receives payment from a source other than Medicaid for the reservation of a bed in a long-term care facility for a particular patient who is not in the facility. Hold bed days do not include therapeutic leave covered by Medicaid.

(16) **Home Office Costs** - See Rule 560-X-22-.20 for in depth discussion and treatment of home-office costs.

(17) **Imprest System** - A system in which any fund is replenished by writing a check equal to the payments which have been made out of the fund. Examples of such funds are petty cash and payroll.

(18) **Interest** - Cost incurred for the use of borrowed funds.

(a) **Necessary Interest** - Incurred to satisfy a financial need of the provider on a loan made for a purpose directly related to patient care. Necessary interest cannot include loans resulting in excess funds or investments.

(b) **Proper Interest** - Must be necessary as described above, incurred at a rate not in excess of what a prudent borrower would have to pay in the money market at the time the loan was

made, and incurred in connection with a loan directly related to patient care or safety.

(19) **Interim Per Diem Rate** - A rate intended to approximate the provider's actual or allowable costs of services furnished until such time as actual allowable costs are determined.

(20) **Medicaid Occupancy** - The percentage of the total patient days reported by a nursing facility utilized by patients whose stay is paid all or in part by Medicaid. This does not include Medicare co-pay days.

(21) **Medicaid Per Diem Rate** - The amount paid by Medicaid for nursing facility services provided to Medicaid patients for a one-day period.

(22) **Necessary Function** - A function being performed by an employee which, if that employee were not performing it, another would have to be employed to do so, and which is directly related to providing nursing facility services.

(23) **Patient Day** - Any day that a bed is either occupied or is not otherwise available for immediate occupancy by a newly admitted patient, but only if some payment and/or promise of payment is received either at the full per diem rate or a reduced rate.

(24) **Proprietary Provider** - Provider, whether a sole proprietorship, partnership, or corporation, organized and operated with the expectation of earning profit for the owners as distinguished from providers organized and operated on a nonprofit basis.

(25) **Provider** - A person, organization, or facility who or which furnishes services to patients eligible for Medicaid benefits.

(26) **Prudent Buyer Concept** - The principle of purchasing supplies and services at a cost which is as low as possible without sacrificing quality of goods or services received.

(27) **Related** - The issue of whether the provider and another party are "related" will be determined under the HIM-15 rules as to classification as "related" parties. (See HIM-15.)

(28) **Reasonable Compensation** - Compensation of officers and/or employees performing a necessary function in a facility in an amount which would ordinarily be paid for comparable services by a comparable facility.

(29) **Reasonable Costs** - Necessary and ordinary cost related to patient care which a prudent and cost-conscious businessman would pay for a given item or service.

(30) **State Plan** - The State Plan promulgated by the State of Alabama under Title XIX of the Social Security Act Medical Assistance Program.

(31) **Straight Line Method of Depreciation** - Depreciation charges spread equally over the estimated life of the asset so that at the expiration of that period the total cost that was determined to be recoverable through such charges has been recovered.

(32) **Unallowable Costs** - All costs incurred by a provider which are not allowable under the Medicaid Reimbursement Principles.

(33) **Lease** - An agreement in which the facility pays for the use of buildings or equipment. Such agreements must not meet the criteria for capitalization as outlined in HIM-15.

(34) **Nursing Facility/Institution for Mental Diseases** - A nursing facility that provides care only for patients diagnosed with Mental Disease and are over sixty-five (65) years of age.

(35) **Nursing Facility/Institution for the Developmentally Disabled** - A nursing facility that provides care only to physically and mentally disabled patients who are eighteen years of age or less.

(36) **Standard Value** - A dollar value per bed used to cover the value of land, buildings, and major movable equipment.

(37) **Current Asset Value** - Standard value per bed reduced by 1% for each year of age, limited to $12,500 per bed minimum.

(38) **Net Asset Value** - Current asset value reduced by outstanding allowable mortgage debt.

(39) **Rebasing** - A mechanism for reflecting inflation in land, buildings, and equipment costs.

(40) **Median** - The middle value in a distribution, above and below which lie an equal number of values.

(41) **Operating Costs** - Administrative and general expenses of running a nursing facility. See Rule 560-X-22-.10 for a more detailed description.

(42) **Direct Patient Care Cost** - Costs that are directly related to providing nursing care to a resident. They consist of direct nursing costs, raw food costs, and fees paid to medical directors, pharmacy consultants, dental consultants, and nursing consultants required by federal and/or state law.

(43) **Indirect Care Cost** - All non-property costs not covered under operating costs and direct care costs. These costs consist of dietary costs (less raw food) housekeeping costs, plant operating costs, activity costs, social service costs, laundry costs (less

the cost of doing patient personal laundry) and miscellaneous cost.

(44) **Fair Rental Cost** - The cost associated with acquiring and using real property (land, buildings, and major movable equipment) not including interest expense, property taxes, and property insurance. See Rule 560-X-22-.14 for more detail.

(45) **Therapy Services Cost** - Costs associated with providing therapy services to residents for physical therapy, occupational therapy, and speech-language pathology are considered allowable. The costs include salary and wages, contract labor expenses and therapy related supplies delivered by licensed professionals and related aides, as required by federal and/or state law. Therapy services reimbursed by non-Medicaid payer sources are not allowable for Medicaid cost reporting and reimbursement purposes.
Author: Sandra Johnson, Director, Provider Audit
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. Amended effective January 4, 1984; March 12, 1988; July 12, 1988. **Emergency rule** effective May 1, 1990. Amended effective August 14, 1990; October 1, 1990. **Emergency rule** effective September 12, 1991. **Amended:** effective December 12, 1991. **Amended:** Published February 27, 2026; effective April 13, 2026.

560-X-22-.04 Nurses Continuing Education.

Mandated Continuing Education Units for nurses and inservice training for nurse aides will be an allowable cost in the direct cost center if it was received in the State of Alabama. All other education cost will be accounted for in the operating cost center.
Author: Bob Murphy
Statutory Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. § 447.200 - .272, et seq.
History: Rule effective August 12, 1992.

Ed. Note: Previous Rule 560-X-22-.04 entitled Budget Variance effective October 1, 1982. Repealed by amendment of Chapter 560-X-22 effective October 1, 1990.

560-X-22-.05 Medicaid Per Diem Rate Computation.

(1) The Medicaid per diem rate will be determined under reimbursement methodology contained in this chapter. (See Rule 560-X-22-.06.) The rates will be based on the cost data contained in cost reports (normally covering the period July 1 through June 30th). In order to allow adequate time for a provider to prepare and submit the cost report and for Medicaid to compute a new rate,

each provider will be paid an interim per diem rate. This interim rate will cover the period July 1 through December 31. The interim rate shall be the lower of the latest allowable computed rate or the ceiling rate per day. The allowable rate per day shall be trended by the Alabama Medicaid trend factor. [See Rule 560-X-22-.07(4)] Providers will be paid a weighted per diem rate for the portion of the fiscal year remaining after the provider's new rates are established. The weighted per diem rate will be determined as outlined below:

(2) To calculate the weighted per diem rate: Multiply the allowable per diem rates times twelve. Deduct from that product the interim per diem rate multiplied by the number of months paid. Divide the remainder by the number of months remaining in the fiscal year.

(a) Example 1. Provider's interim rate has been in effect for five (5) months. Provider's weighted rate will be in effect for seven (7) months:

Allowable per diem rate for the year	$ 50.00
Interim rate paid	$ 48.00
Allowable per diem rate multiplied by 12 = $50.00 x 12	$ 600.00
Deduct interim per diem rate multiplied by number of months paid = $48.00 x 5 =	$ 240.00
Remainder =	$ 360.00
Divide the remainder by the number of remaining months in the fiscal year = $360.00 - 7 = Weighted per diem rate =	$ 51.43

(b) Example 2. Provider's interim rate has been in effect for six (6) months. Provider's weighted rate will be in effect for six (6)months:

Allowable per diem rate for the year	$ 50.00
Interim rate paid	$ 48.00

Allowable per diem rate multiplied by 12 = $50.00 x 12	$ 600.00
Deduct interim per diem rate multiplied by number of months paid = $48.00 x 6 =	$ 288.00
Remainder =	$ 312.00
Divide the remainder by the number of remaining months in the fiscal year = $312.00 - 6 = Weighted per diem rate =	$ 52.00

(c) Unapproved Beds. Capital expenditures must be approved under the State Certificate of Need Program.

Author: Michael C. Murphy, Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. **Amended:** effective March 15, 1983; May 9, 1984, September 8, 1984. **Emergency rule** effective December 1, 1986. A permanent rule incorporating the provisions of this emergency rule was not adopted and therefore the original wording in paragraph 5 was reinstated upon expiration of the emergency rule. **Amended:** effective September 9, 1987; March 12, 1988; June 14, 1989. **Emergency rule** effective June 20, 1989. **Amended:** effective September 13, 1989. **Emergency rule** effective January 17, 1990. **Amended:** effectiveApril 17, 1990; October 1, 1990. **Emergency rule** effective September 12, 1991. Amended effective December 12, 1991.

560-X-22-.06 Reimbursement Methodology.

(1) All nursing facilities will be grouped into three (3) functional categories:

(a) Nursing Facility (NF).

(b) Nursing Facility/Institution for Mental Disease (NF/IMD).

(c) Nursing Facility/Institution for the Developmentally Disabled (NF/IDD).

(2) The following methodology shall apply: Cost reports, as submitted, will be desk audited for any unallowable costs, and those costs will be removed from the subsequent computations. The

providers' reported allowable costs will be used as the basis for calculating the new per diem rates. All similar allowable costs will be categorized into one of the four (4) groups: operating costs, direct patient care cost, indirect patient care cost, and property cost. NF/IMD and NF/IDD facilities will be exempt from all ceilings. The following methodology will be used for determining the per diem rates for approved beds. Ceilings are to be limited to the previous year's ceiling increased by no more than four (4) percentage points over the DRI inflation index. Should the computed ceiling exceed that index, the lower amount will be used. For example:

FY 96 ceiling	= $50.00
DRI index	= 3.5%
Limit	= $50.00 + (.035 + .04)($50)
	= $50.00 + $3.75 = $53.75
Computed Ceiling	= $54.50
FY 97 Ceiling	= $53.75

(a) Operating Cost Center. The allowable management and administrative costs (See Rule 560-X-22-.10), after inflation index is applied, for each facility will be divided by reported patient days. All nursing facilities will be grouped by the number of beds in the facility and the operating costs for each facility will be separated into two bed size groupings, 75 beds or less and 76 beds and over. Each grouping will be arrayed by the cost per patient day and the median plus 5% will be determined for each grouping and that will be the ceiling. This ceiling, or actual cost, whichever is less, will be used for each provider's rate computation.

(b) Direct Patient Care Cost Center. Direct care costs, after inflation index is applied, consisting of nursing services, raw foods, medical director, nursing consultant, pharmacy consultant, and dental consultant for each facility will be divided by reported patient days. These costs per patient day will be arrayed and the ceiling for the direct patient care cost center will be the median cost per patient day plus 10%. The provider's actual allowable reported cost per patient day plus 10% not to exceed the established ceiling plus 10%, whichever is less, will be used for each provider's rate computation.

(c) Indirect Patient Care Cost Center. Costs for plant operations, dietary (minus raw foods), laundry (less costs associated with patient personal laundry), activities, social services, housekeeping, beauty and barber (if provided free of charge by the facility), dietary consultant, social services consultant, and other allowable costs, after inflation index is applied, will be divided by reported patient days. These costs per patient day will be arrayed and a median cost per patient day will be determined. The ceiling for indirect patient care costs is the median cost per patient day plus

10%. The provider's actual allowable reported cost per patient day plus 50% of the difference between actual allowable cost and the established ceiling, up to the ceiling amount, will be used for each provider's rate computation.

(d) Therapy Services Patient Care Cost Center. Costs for physical therapy, occupational therapy, and speech-language pathology services shall be reported under the Therapy Services Patient Care Cost Center. Allowable costs include salaries, wages, contract labor, and therapy-related supplies for services provided by licensed professionals and related aides, in accordance with applicable federal and state regulations.

Subject to the approval of a State Plan Amendment, beginning state fiscal year 2026, and for Medicaid reimbursement rates set thereafter, costs for Medicaid therapy services, including physical therapy, occupational therapy, and speech-language pathology, will be considered allowable costs. To reimburse these covered services, a per patient day therapy services rate add-on will be implemented. To calculate Medicaid Therapy Services Patient Care costs, a therapy charge apportionment methodology will be applied. This methodology will calculate Medicaid therapy discipline
charges as a percentage of total therapy discipline charges. This applicable percentage will then be multiplied by the associated total therapy discipline costs to determine Medicaid’s share of therapy costs. Total Medicaid therapy costs will be the combined sum of therapy costs for each therapy discipline. The resulting Medicaid therapy costs, after applying an inflation index, will be divided by the reported Medicaid patient days to determine the Medicaid Therapy Service Patient Care Cost per diem. Reimbursement for Medicaid therapy services will be the result of this calculation. The Medicaid Therapy Service Patient Care Cost per diem for all facilities shall not exceed the limitation of $2 per Medicaid patient day in the aggregate. The aggregate therapy add-on for each upper payment limit group shall be the product of the total allowable therapy costs divided by the total covered Medicaid days from Medicaid claims data. Beginning with per diem rates effective January 1, 2028, the $2 aggregate limitation shall be increased every year by the Medicaid Inflation Index. If the aggregate limitation is exceeded, all facilities shall have their therapy services rate add-on reduced by the uniform percentage necessary to meet the aggregate limitation. Therapy charges must be based on a uniform and consistent charge structure for all payor types.

(e) Property Cost Center. In lieu of depreciation expense, lease expense, and a return on equity, a fair rental return (see Rule 560-X-22-.14 for detailed explanation) will be computed for each provider using the following procedure:

1. A current asset value per bed will be established. This current asset value will initially be set using the standard value of $25,000 per bed and reducing by 1% for each year of age, or fraction of 1% for partial years, not to exceed a 50% reduction or a minimum value of $12,500 which will be applied as a floor. In order to keep pace with rising construction costs, a rebasing system will be established. The mechanism for rebasing will be to index the current asset values each year. The Marshall-Swift Evaluation Service will be used for adjusting to inflation.

2. A gross rental factor of 2.5% will be multiplied by the current asset value of the facility to determine the rental value of the facility.

3. The "Rate of Return on Current Asset Values" will be computed in two parts. First, the current asset value of the facility, less the balance due on allowable notes incurred to purchase all land, buildings, and equipment, will be multiplied by the "current yield on 30 year U. S. Treasury Bonds" as of June 30th each year. Second, the current asset value will be multiplied by a "risk premium of 1.5% for ownership." The two products will then be added together.

4. Interest expense related to allowable notes incurred to purchase land, buildings, and equipment will be determined.

5. Property taxes and property insurance costs will be determined.

6. The rental value, rate of return, allowable interest, property taxes, and property insurance costs, less laundry adjustment from Fair Rental, will be totaled and that total will be divided by the facility's reported patient days to determine the facility fair rental payment which will be used to compute the facility's rate.

(f) After the operating costs, direct patient care costs, and indirect patient care costs have been added together, the allowable property costs are added. The resulting costs is the rate per patient day for the cost report year.

(g) Example:

1. Operating Costs (actual allowable reported costs per patient day up to the ceiling).

2. Direct Patient Care Costs (actual allowable reported cost per patient day plus 10% not to exceed the established ceiling plus 10%).

3. Indirect Patient Care Costs (actual allowable reported cost per patient day plus 50% of the difference between the reported cost and the ceiling up to the ceiling amount).

4. Total of Items 1, 2, and 3.

5. Allowable Property Costs.

6. Allowable Therapy Services Patient Care Costs (actual Medicaid allowable cost per Medicaid patient day up to the aggregate limitation.

7. Laundry fee-for-service.

8. Total of Items 4, 5, and 6.

(h) NF/IDD facilities will not be subject to the above outlined ceilings; however, their rates will be computed in a like manner.

(i) NF/IMD facilities and any other facility owned and operated by the State of Alabama will have their rates computed in the above manner, but will not be eligible for incentive payments in the direct care and indirect care areas, nor will they receive a Fair Rental payment. Instead, their rates will be determined using actual cost with no ceiling limitations and a usage allowance for property costs (2% for buildings and 6 and 2/3% for equipment).

(3) Ceilings Not Subject to Adjustments. Once the ceiling has been established for a fiscal year, it will be final and not subject to revision or adjustment during that year. However, at the discretion of the Agency, it may be changed upon discovery of material error. Since the ceiling rate is based on information provided in the cost reports, it is to the benefit of each provider to ensure that their information is correct and accurate. If obvious errors are detected during the desk audit process, providers will be given an opportunity to submit corrected data.

(4) After the rates have been set, each provider will be notified of its rate. If the provider has questions regarding any disallowances made during the rate setting process, they may request further information in writing. Only those requests submitted in writing will be honored.

(5) During the fiscal year, the Commissioner of Medicaid will consider extraordinary expenditures which are not reasonably foreseeable and are totally beyond the control of the provider.

(Example: Additional personnel or equipment mandated by federal or state governmental agencies.) Such expenditures do not include those which can be reasonably anticipated in connection with inflation, such as employee compensation increases and employee benefit increases. Requests to Medicaid for consideration must be fully substantiated, to include the reason for the request, total computed cost, effective date and other supporting data, as pertinent.

(a) Costs [as referenced in (5) above] which are approved and added to a projected rate during the period January 1 - June 30 are subject to retroactive settlement upon submission of the next cost report. Costs which are approved and added to a rate during the rate period July 1 - December 30 shall be settled through the next rate weighting cycle (January 1 - June 30).

(6) The monthly rate is computed by multiplying the per diem rate by 30.42 days. This rate is valid for patients in the nursing facility for the full month. For partial monthly coverage, the per diem rate is multiplied times the number of days.

(7) Dollar values are rounded.

(8) Effective July 1, 1989, the reasonable allowable costs of compliance with the provisions of §4211 OBRA 87 as incurred by nursing facilities for nurse aide competency evaluation and training is recognized for purposes of reimbursement. Reimbursement for these costs will be as follows:

(a) For those employees hired prior to July 1, 1989, nursing facilities will be reimbursed the Medicaid share (based on percentage of occupancy) of costs associated with the original competency evaluation as incurred and documented. These costs will be reimbursed as a pass-through item outside the per diem rate, not subject to the 60th percentile upper limit.

(b) For the period July 1, 1989, through December 31, 1989, nursing facilities will budget the allowable costs of nurse aide training and competency evaluation. The resulting amount per day, for these costs only, will be added to existing per diem rates outside the 60th percentile limitation. These budgeted costs will be subject to retroactive adjustment when the actual cost is verified.

(c) Subsequent reimbursement of nurse aide competency evaluation and training expenses will be paid outside of the normal per diem system. Nurse aide training expenses allowed to be paid outside the normal per diem system are costs of the test, any charge for training by other than the facility, necessary supplies, and cost of transportation of the aide to the training or testing site. These expenses should be reported in the unallowable section of the cost report, on a

separate line, and identified as nurse aide training expenses. An attachment to the cost report is required itemizing expenses. If equipment costs are included, the normal capitalization policy will apply. These expenses will be extracted from the cost reports and paid at a later date as a separate payment. Under the current rules, these procedures will continue into future years.

(d) Equipment used in nurse aide competency evaluation and training. Reimbursement for equipment (i.e., ProCare) will be reimbursed by one of the following methods:

1. Will be recognized as medical specialized equipment and capitalized and depreciated over a useful life of three (3) years, or

2. A rate of $30.00 will be paid for each nurse aide that is trained and passes the competency test.

(e) Because nurse aide training is considered an administrative cost by HCFA and has a federal match of 50%, these costs cannot go through the cost report. These costs must be reported in the "unallowable" section of the cost report and will be paid as outlined in (c) above.

Author: Sandra Johnson, Director, Provider Audit
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. Amended effective July 9, 1984; August 11, 1986; March 12, 1988; July 13, 1989. **Emergency rule** effective January 22, 1990. Amended effective April 17, 1990. **Emergency rule** effective May 1, 1990. Amended effective May 15, 1990; August 14, 1990; October 1, 1990. **Emergency rule** effective September 12, 1991. Amended effective December 12, 1991; August 12, 1992. **Amended:** Filed December 8, 1997; effective January 12, 1998. **Amended:** Published February 27, 2026; effective April 13, 2026.

560-X-22-.07 Medicaid Inflation Index.

(1) The Medicaid Inflation Index will be used in lieu of budgeting to adjust certain actual allowable costs from one reporting period for the purpose of computing the per diem rate payable for a subsequent reporting period and for such other adjustments as may be specified in this chapter.

(2) The Medicaid Inflation Index shall be based upon the economic indicators as published by Data Resources, Inc., (DRI) for the Department of Health and Human Services. The indicators shall be the Market Basket Index of Operating Costs - Skilled Nursing Facility, which are published quarterly, whereas the Medicaid fiscal year for cost reporting and rate setting purposes ends on

June 30th. Therefore, the Medicaid Inflation Index for a rate period will be the DRI Index for the twelve-month period ending on the calendar quarter for which the index has been published or made available at October 1st of each year.

(3) The Medicaid Inflation Index will be established each October 1st for the current fiscal year based upon the information then available to Medicaid and will not be adjusted again until the next following October 1st, regardless of anylater release of revised or additional information relevant to the determination of the index.

(4) Interim Inflation Factor. The interim rate shall be the lower of the latest allowable computed rate [Rule 560-X-22-.05(l)(b)] or the ceiling rate per day. The applicable allowable rate per day shall be trended by the Alabama Medicaid trend factor. The trend factor shall be the National Forecast-Nursing Home Market Basket for the following fiscal year as published by Data Resources, Inc. This forecast is published quarterly; therefore, the latest forecast available at June 1st each year shall be used.
Author: Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., §§447.200 - .272.
History: Rule effective October 1, 1982. Amended effective September 8, 1984; July 9, 1985. **Emergency rule** effective October 1, 1990. Amended effective October 1, 1990; December 14, 1990.
Amended: Filed December 8, 1997; effective January 12, 1998.

560-X-22-.08 Patient Days.

(1) A patient day is incurred when any one of the following conditions have been met:

(a) Care is rendered to a patient in the facility. This results when a patient is rendered services between the census taking hour (12:00 midnight) on two (2) successive days. The following procedure illustrates the proper method of determining the number of patient days resulting from care rendered to patients in the facility, using the midnight census method:

1. Number of patients in the facility at midnight.

2. Add/subtract patients admitted/discharged (including deaths) prior to midnight of the following day (Exception - a patient admitted and discharged on the same day counts as a patient day.) The provider may bill for the date of admission, but not for the day of discharge.

(b) When preadmission payments are received to ensure a bed is kept open for a particular patient. The rationale for

including these payments lies in the fact that this bed is not available for occupancy by another patient. Since the facility is receiving payment for a bed which is, in effect, unavailable to any other patient, it should be included in patient day totals.

(c) When a patient is out of the facility, regardless of the reason, and the nursing facility is receiving payment for the bed, this day is counted in the same manner as preadmission payments as stated above. If the nursing facility is not receiving payment for the bed, it will not be counted as a patient day.

(d) Medicaid payment will only be made for therapeutic visits not to exceed three (3) days per visit and six (6) such visits per patient during any twelve-month period. Visits are limited to two (2) per calendar quarter to home, relatives, and friends. Limitations do not apply to patients in institutions for the intellectually disabled or persons with related conditions. The long-term care facility must ensure that each therapeutically indicated visit by a patient is authorized and certified as necessary by a physician. (See Schedule 8-A at end of chapter.)

(2) Minimum records required to be kept at the facility are:

(a) Midnight census by patient name at least one time per calendar month. More frequent census taking is recommended.

(b) Ledger of all admissions and discharges/deaths.

(c) Complete therapeutic leave records.

(d) A monthly analysis sheet which summarizes all admissions and discharges, paid hold bed days, and therapeutic leave days. (Schedule 8-A at end of chapter is the recommended analysis sheet; however, providers may utilize any form of their own design if it provides the same information.)

(3) In the event that payment for a preadmission day is not received and the charges are subsequently written off as uncollectable, the facility will not count those days as patient days. The facility must keep a separate ledger to indicate days in this category. The ledger must indicate the following:

(a) Patient name,

(b) Dates of preadmission days charged,

(c) Dates of preadmission days written off as uncollectable,

(d) Reason for uncollectability.

Author: Sandra Johnson, Director, Provider Audit

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. Amended effective May 15, 1983; August 10, 1983; October 1, 1990. **Amended:** Published January 31, 2024; effective March 16, 2024.

560-X-22-.09 Staffing.

(1) Providers are expected to staff nursing care functions in accordance with state licensure requirements.

(2) Staffing of each functional area within each facility will be reviewed by Medicaid for reasonableness.

(3) An adjustment will be made to decrease allowable costs for facilities which are deemed to be overstaffed in any particular functional area.
Author: Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. Amended effective October 1, 1990.

560-X-22-.10 Management And Administrative Costs.

(1) Costs of a management or administrative nature, including but not limited to those costs outlined in Rule 560-X-22-.10(3), will be reported as such on the Medicaid Cost Report. Salaries of administrative personnel which would duplicate employee salary expenses in other cost centers cannot be allocated to such nonadministrative cost centers.

(2) Customarily, owner compensation results from a distribution of the profits. However, when the owner provides a necessary service to the facility, he/she can justifiably be compensated at a reasonable rate, then that owner compensation is an allowed cost. "Reasonable compensation" must meet the criteria of being paid to an employee who performs a necessary function in a facility and must be in an amount which would ordinarily be paid for comparable services in a comparable facility. To be "necessary," a function must be one that if that employee were not performing it, another would have to be employed to do so, and, additionally, the function must be directly related to providing nursing facility services.

(3) Examples of Allowable Management and Administrative Costs include, but are not limited to:

(a) Salaries and Bonuses:

1. Administrator.

2. Assistant Administrator.

3. Accountant.

4. Bookkeeper.

5. Computer Operator.

6. Medical Records Clerk.

7. Personnel Officer.

8. Secretary.

9. Typist.

10. Clerks.

11. Receptionist.

12. Telephone/Operator/Switchboard.

(b) Legal Fees (Legal fees related to patient care, except those specified in Rule 560-X-22-.22).

(c) Consultants - Medical Records.

(d) Outside Accounting and Auditing:

1. Routine Bookkeeping.

2. Preparation of costs reports.

3. Auditing and related statement.

(e) Data Processing:

1. Owned.

2. Rented.

3. Outside purchased service.

(f) Professional Development.

(g) Supplies:

1. General administration.

2. Medical records.

(h) Telephone Expense - Subject to limitations in Rule 560-X-22-.22(3)(v).

(i) License:

1. Business.

2. Administrator's.

3. Direct care professional staff (to be reported in the appropriate functional cost center).

4. Professional staff if their employment negates the need for contracting with a consultant (to be reported in the appropriate functional cost center).

(j) Insurance: Professional Malpractice and related deductibles.

(k) Employee Benefits - Administrative Employees:

1. Group Life.

2. Group Health.

3. FICA.

4. SUI.

5. FUTA.

6. Deferred Compensation Plans, Pension and Profit-Sharing, approved by IRS.

7. Workman's Compensation Insurance.

(l) Advertising:

1. Telephone, local.

2. Employment ads.3. Public Relations ads (not in excess of $100 per fiscal year).

(m) Postage.

(n) Management Home Office Cost (chain operation):

1. Management and administrative salaries and benefits. (To be reported on lines D5-1 and D5-2 as appropriate).

2. All building costs, including but not limited to: (To be reported on line D5-17).

(i) Insurance.

(ii) Rent.

(iii) Lease.

(iv) Utilities.

(v) Depreciation.

(vi) Interest.

(o) Interest Expense on working capital loans, subject to limitations contained in Rules 560-X-22-.11, 560-X-22-.22.

(p) Management fees not exceeding the cost of the provider of the services and not excluded under Rule 560-X-22-.22(3)(a).

Author: Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. Amended effective May 15, 1983. This amendment will apply for cost reports for the fiscal year ending 6-30-83. Amended effective October 1, 1990. **Emergency rule** effective September 12, 1991. Amended effective December 12, 1991.

560-X-22-.11 Interest Expense.

(1) Necessary and reasonable interest expense is an allowable cost. In order to be considered necessary, the interest must be incurred on a loan made to satisfy a financial need directly related to patient care. Loans which result in excess funds or which are not related to patient care are not considered necessary. In order to be considered reasonable, theinterest rate cannot be in excess of that which a prudent borrower would agree to pay, and the lender must not be related to the borrower. The provisions of HIM-15 shall be applicable in determining whether a loan is between related parties. Interest paid by the provider to owners, partners, stockholders, or other persons related to the provider is not an allowable cost.

(2)(a) Bond discounts or premiums and loan costs will be amortized over the life of the bond issue using the straight line method and such amortization will be treated as interest. Amortization will be added to interest expense in the case of discounts and loan costs and deducted from interest expense in the case of premiums.

(b)(1) For purposes of Medicaid reimbursement, the term "discount," as applied to debt, means any front-end payment to a lender or any reduction of principal received from a lender

as a condition of obtaining the loan. It encompasses the generic terms of discount, loan points, and commitment fees.

(b)(2) Allowable loan costs will be limited to expenditures required by the lender, such as title searches, recording fees, etc.; however, fees for project development, feasibility studies, or financial advisors will not be allowed.

(c) Only the portion of the discount or premium and loan cost that is related to the allowable basis of the facility, as determined by Medicaid, can be amortized and claimed for reimbursement. Allowable portion will be computed as follows: Current Asset Value x Current Unamortized Disc./Premium = Allowable Discount/Premium Balance Due on Note. Should the result be more than 100%, the full discount/premium will be allowed.

(d) Interest expense will be allowed for debt, discount and/or premium, and loan costs that are related to the allowable Medicaid basis. The computation of the allowed loan cost will be the same as for allowable discounts as described in 560-X-22-.11(2)(c).

(e) Example:

1. Outstanding Debt at 9/1/91 $2,500,000

2. Remaining Term of Debt 25 years

3. Interest Rate 10%

4. Current Asset Value at 9/1/91 1,826,000

5. Discount 125,000

6. Escrows 150,000

7. Loan Costs (Subject to the provisions of 560-X-22-.11(2)(b)(2) 560-X-22-.22(3)(e)(f)) 120,000

8. Allowable Interest Computation:

(i) Allowable Discount

1,826,000 x 125,000 = $91,300

2,500,000

(ii) Allowable Loan Cost

1,826,000 x 120,000 = $87,648

2,500,000

(iii)

Medicaid Basis	$1,826,000
Discount	91,300
Loan Cost	87,648
Total Int. Basis	2,004,948

(iv) Interest & Debt Allowable

2,004,948 = 80.2% of Annual Interest Incurred

2,500,000 on Notes Outstanding

(v)

First year Interest	$250,000
Medicaid Allowable	.802
Allowable Interest	200,500
Allowable Amortization:	
Discount	91,300
	253,652
Loan Cost	87,648
	253,506
Total Reimbursable Int. and Amortization	$207,658

(vi) Once percentages of allowability have been established, they will remain in effect until there is a change in ownership. Sale of stock or corporate reorganization does not constitute a change of ownership. A revaluation of assets will be permitted where the purchase of stock of a corporate provider is followed within three (3) months by the liquidation of the provider. Any revaluation of the assets of a provider as the result of such liquidation shall be subject to the same prior approval and basis limitations as though an outright sale of the assets has been made.

(3) Interest incurred during the period of construction on funds borrowed to construct, improve, or enlarge existing facilities must be capitalized as a part of the cost of the facility. The period of construction is considered to extend to the date the facility, improvement, or renovation is put into use for patient care. Where a bond issue is involved, any bond discount and expense, or bond premium amortized during the period of construction must be capitalized and included in the cost of the facility constructed.

(4)(a) If a debt which was incurred to finance the construction, expansion, renovation, or acquisition of a nursing facility is refinanced, allowable interest on the new loan will be limited to that portion of the loan that represents the unpaid allowable balance of the previous loan subject to the methodology outlined in (2)(e) above. Interest expense, plus applicable amortization cannot exceed the amount that would have been allowable under the terms of the previous loan agreement.

(b) When a loan is refinanced, any allowable unamortized discounts/premiums and loan costs will be written off the provider's books. Such written-off amounts will be treated as a prepayment penalty subject to the provisions of paragraph (5) below.

(5) If the provider incurs a prepayment penalty on the early extinguishment of an interest bearing debt, such penalty may be an allowable cost subject to the following guidelines:

(a) If the allowable interest incurred, plus the penalty (prorated for the allowable portion of the debt) does not exceed the interest that would have been allowed had the debt not been paid off, then all of the interest and penalty can be claimed.

(b) If the allowable interest incurred, plus the penalty (prorated for the allowable portion of the debt) exceeds the interest that would have been allowed had the debt not been paid off, claim may be made for the amount that would have been allowed had the debt not been paid off. The excess penalty may then be carried forward and claimed in subsequent years in a manner such that actual interest incurred, plus penalty does not exceed the interest that would have been allowable under the previous financing agreement.

(c) In no instance will the provision of (5)(b) be carried forward in excess of five years.

(6) The payment of a lease payment to a medical clinic board, under a lease agreement containing a purchase option at aprice below the fair market value, is generally not allowable as a true lease payment. It will generally be treated as a lease purchase which must be capitalized. Payments of bond interest will be subject to the above outlined provisions.

(7) Financing that provides for no scheduled periodic reduction of the principle amount of the loan will not be recognized by Medicaid. The provider will, instead, submit to the Chief Auditor, Provider Audit, such information as necessary in order to generate an appropriate amortization schedule for the loan amount. This schedule will be used to compute allowable interest as outlined in paragraph (2)(e) above.

(8)(a) Interest must be reported on the cost report in two distinct areas: working capital interest in the administrative cost center (subject to the operating cost center ceiling), and other interest reported in the Fixed Cost Center.

(b) Working capital interest is limited to short term loans (normal term of less than six months) taken out to meet immediate needs of daily operations. To be allowable, there must be a genuine effort by the provider to repay these notes. If no evidence of repayment is apparent and these notes are merely renewed throughout the year, Medicaid will not consider these to be bona fide working capital notes; and the interest incurred on them will not be allowable if no justification can be made for nonpayment of the note. Allowable interest on working capital notes will be limited to no more than 90 days interest on two months of the provider's average allowable cost net of property cost. The rate used for this computation will be the average rate charged by the lender during the year, as reported on schedule L of the cost report.

(9) Only interest expenses incurred and payable to a lender, as evidenced by a signed loan agreement, will be considered for reimbursement. Additional interest expense created by restatement of loan agreements, under generally accepted accounting principles, or created by imputing a different rate from the one stated in the loan agreement, will not be allowable. For example, an imputed interest expense resulting from the application of Accounting Principles Board Opinion No. 16 or No. 21, or any similar accounting principle, and any other imputed interest expense shall not be recognized as a valid interest cost for purposes of computing the provider's allowable Medicaid reimbursement.

(10) If financing obtained to purchase a facility is a combination of assumed debt and new financing, allowable interest will be prorated among all debt interest; i.e., if the total debtis determined to be 90% allowable, then 90% of the total interest will be allowable.

(11) If loans are made by the facility to related parties during the reporting period and working capital loans are taken out or remain outstanding during any period in which the related party loans are outstanding, then the interest on the portion of the principal amount of such working capital loans equal to the principal amount of such related party loans is not reimbursable.

(12) Providers are required to maintain adequate records to allow for audit verification by Medicaid auditors. Minimum records required are:

(a) Loan/Mortgage Agreements which state the purpose of loan.

(b) Repayment Schedule/Amortization Schedule.

(c) If a loan is refinanced, the above records must also be kept for the prior loan.

Author: Susan Mims
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. Amended effective March 11, 1986; October 1, 1990. **Emergency rule** effective September 12, 1991. Amended effective December 12, 1991.

560-X-22-.12 Laundry Expense.

(1) Allowable costs will be limited to the laundry costs which are ordinary and necessary to the operation of a nursing facility and will not include costs associated with the personal laundry of patients.

(2) Examples of such costs include, but are not limited to, the following:

(a) Salaries and employee benefits attributable to laundry personnel.

(b) Supplies and materials used in providing laundry services.

(c) One and one half percent (1.5%) of Fair Rental to be applied to laundry.

(d) Costs directly attributable to the delivery of laundry.

(e) Charges by an outside laundry.

(3) Allowable salaries and benefits will include all personnel directly involved in performing this service. Delivery costs will be subject to the limitation in Rule 560-X-22-.13, "Travel Expense."

(4) The total cost of handling the personal laundry of patients must be deducted from actual laundry costs. If this cost cannot be separated from other laundry costs, two (2) one-week laundry studies based on weight must be conducted by the facility at six (6) month intervals. The laundry costs will then be reduced by the personal laundry proportion as determined by the studies.

(5) Medicaid will reimburse providers a fixed fee of $1.25 per patient day for providing patient personal laundry service. All providers must offer this service to Medicaid patients. If a patient declines to use the service, a signed statement from the patient and/or his sponsor attesting to this fact must be on file.

Author: Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.

History: Rule effective October 1, 1982. Amended effective July 9, 1984; October 1, 1990. **Emergency rule** effective September 12, 1991. Amended effective December 12, 1991.

560-X-22-.13 Travel Expense.

(1) Travel that is necessary and that is directly related to the operation of the nursing facility claiming reimbursement for the expense will be an allowable cost for reimbursement purposes pursuant to the following specific provisions:

(a) Automobile:

1. Since the form of vehicle ownership, the type, and the number of vehicles utilized will vary depending on a facility's specific needs, reimbursement will be based on a standard mileage rate and will be limited to mileage which is documented by log entries prepared in accordance with either of the attached sample logs. (See Schedules 13-A and 13-B at end of chapter.) Reimbursement to employees for the use of theirpersonal vehicles will be limited to the lesser of the actual reimbursement to the employee or the standard mileage rate per section (1)(a)3. of this rule.

All log entries must be made at the time of travel, and log entries will be subject to verification during audit. Failure to timely and accurately account for travel mileage will result in a disallowance of this cost.

2. Commuting mileage between the commuter's residence and the nursing facility is not allowable mileage for reimbursement purposes. (See Schedule 13-A at end of chapter.)

3. The standard mileage rate is as follows: The IRS mileage rates in effect on January 1 of the calendar year in which the cost report is filed (January 1, 1990, for cost reports filed as of June 30, 1990). These rates will be applied on a per provider basis regardless of the number or type of vehicles used. (See Schedule 13B at end of chapter.) In addition to the mileage rate listed above, up to $1,000 in actual operating costs (i.e., gas, oil, upkeep) of one automobile per nursing facility may be reimbursable. There will be no additional reimbursement in those instances in which the facility auto is used for commuting purposes of the administrator or nonpatient care related activities. To qualify for this additional allowance, the facility must own or lease a vehicle, the vehicle must be used only for purposes of patient care, and actual operating expenses must exceed

the computed mileage allowances. In no instance will the facility be allowed to claim more than the standard allowance plus the $1,000 (if computed allowance is less than operating cost) or actual operating costs, whichever is less.

Examples:

Facility Owns Vehicle	Medicaid Mileage Allowance	Actual Operating Expense	Allowance
Yes	$ 2,325	$ 2,115	$ 2,325
Yes	$ 2,325	$ 4,125	3,325
Yes	$ 2,325	$ 2,765	2,765

If the facility does not own a vehicle, reimbursement will be limited to actual payments to employees for use of their personal automobiles for documented facility business, provided that such reimbursements do not exceed the allowable rates. (IRS guideline)

4. No additional reimbursement in excess of $1,000 will be recognized for any other automotive-related cost. Thoseadditional costs which will not be recognized include, but are not limited to:

(i) Depreciation.

(ii) Interest on automotive loans.

(iii) Lease/rental expense.

(iv) Taxes, tags and insurance.

(v) Return on equity.

5. No reimbursement will be made or considered for unusual or impractical vehicles, which include but are not limited to aircraft, motorcycles, farm equipment and other vehicles not necessary to the efficient operation of the facility.

(b) Other travel:

1. Costs of travel to out-of-state conventions or association meetings will be limited to those reasonable costs incurred by a facility for two trips during each fiscal year. If the facility bears the expenses of two persons attending the same convention or association meeting, such attendance will be counted as two trips. Reimbursement will be considered only for bona fide employees of the facility whose attendance will benefit the operation of the facility. Expenses related to travel

expenses of employee spouses will not be eligible for reimbursement unless the spouse is a bona fide employee of the facility and has a legitimate reason, related to patient care, for such attendance. Since only patient care related travel is allowable, evidence must be on file to verify that the travel was patient care related. Such evidence may be: (a) seminar registration receipts, (b) continuing education certificates, (c) similar documentation. If verification cannot be made, reimbursement will not be allowed. Out-of-state travel living expenses will be limited to $125 per day for the length of the functions attended. Per diem for the date of return will be limited to $50.00 because lodging is not required.

2. Transportation expenses in- or out-of-state will be limited to the ordinary and necessary costs of transportation, food, lodging, and required registration fees.

3. Whenever out-of-state travel could be accomplished at a lower cost by utilizing air travel, reimbursement will be limited to the costs which would have been incurred if such airtravel had been utilized and the costs normally incident to such air travel (meals, lodging, etc.).

4. No travel expenses of a nonbusiness nature will be reimbursed.

5. Travel which requires an overnight stay must be documented by a travel voucher which includes the following:

(i) Date.

(ii) Name of person.

(iii) Destination.

(iv) Business purpose.

(v) Actual cost of meals and lodging (lodging must be supported by invoices, meal receipts must indicate number of meals served for any meal in excess of $20.00).

(vi) Air, rail and bus fares (supported by an invoice).

Author: Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. Amended effective May 15, 1983; July 9, 1984; September 8, 1984; February 9, 1989;

October 1, 1990. **Emergency rule** effective September 12, 1991. **Amended:** effective December 12, 1991.

560-X-22-.14 Property Costs.

(1) In order for any property costs to be reimbursed through the Medicaid program, capital expenditures must be approved under applicable Certificate of Need regulations by appropriate state and/or federal agencies. Capital expenditures, as used in this chapter, means new construction, major renovations, bed additions, or replacement beds in a nursing facility.

(2) Effective September 1, 1991, a Fair Rental System will be used to reimburse property costs. The Fair Rental System reduces the wide disparity in the cost of capital payments for basically the same service and makes the cost of capital payment fairer to all participants in the program. The Fair Rental System is a rate of return on current asset values and will be used in lieu of depreciation and/or lease payments on land, buildings,and major movable equipment normally used in providing patient care.

(3) The following factors will be used to arrive at a "Rate of Return on Current Asset Values":

The current yield on 30 year U. S. Treasury Bonds*	
A risk premium for ownership	1.5%
A Gross Rental Factor	2.5%

*Latest yield as of June 30

(4) The amount of $25,000 per bed will be used to reflect the standard value per bed as of September 1, 1991. This standard value reflects the allowable cost of a newly constructed facility to include land, buildings, and all major movable equipment needed to place the facility in operation.

(5) Current asset values are found by taking the standard value of $25,000 per bed and reducing that amount by 1% for each year, or fraction thereof for partial years, of age for a maximum of 50 years. A minimum value of $12,500 per bed will be applied as a floor. Once these values have been set, they will be subject to rebasing yearly using the Marshall-Swift Valuation Service data. They will not be subject to further reduction for age.

(6) Net asset values are found by taking current asset values and reducing them by outstanding allowable debt for land, building, and equipment. Allowable debt is determined by subtracting any escrow funds related to the debt from the current balance due. The

remainder will be considered allowable debt up to the amount of the facility's current asset value.

(7) The following property costs will normally not be reimbursed under this Fair Rental System: (a) depreciation and (b) rent for land, buildings, and equipment.

(8) Sale of Existing Facilities: Effective for sales closed on or after September 1, 1991, the allowable basis to the purchaser of an existing facility in the Medicaid Program will be the Current Asset Value of the previous owner.

(9) New Facilities. In the year in which a new facility is opened, the most recently computed standard asset value will be used to determine fair rental values.

(10) Renovations. If a provider makes a major improvement or renovation to the facility, the current asset value of the facility may be adjusted by Medicaid. Renovations for the purpose of this chapter shall be defined as real and fixed property changes to a nursing facility. Any major improvement or renovation to the facility related to the provision of therapy services as defined by 560-X-22-.03(45) shall not be included in this definition. The American Hospital Association publication, "Estimated Useful Lives of Depreciable Hospital Assets," tables 2, 3 and 4 will be used to determine real and fixed property affected by this rule. Facilities wishing to make renovations must submit the renovation project to Medicaid for approval. Facilities submitting a renovation project must fully define the project and include all anticipated and projected costs of the project. At the time of completion of the renovation project, the cost projections should not exceed the original costs submitted plus fifteen percent (15%). Medicaid will approve or disapprove the renovation project within thirty (30) days of receipt. Renovation projects receiving disapproval will be given the reason for disapproval. Facilities receiving a disapproval will be given an opportunity for an appeal in accordance with Rule No. 560-X-22-.27. Renovation projects approved will be issued a certificate of approval. The certificate of approval will be valid for a period of twelve (12) months from the date of approval. If a facility, due to unexpected circumstances, is unable to complete the renovation project within the original twelve (12) months, the Medicaid Agency may grant an extension of no more than twelve (12) additional months. Medicaid will adjust the current asset value and set an interim rate for the facility during the month in which the renovation project is complete and all final invoices are submitted to Medicaid. Improvements and/or renovations costing less than five percent (5%) of the current asset value at the time of the renovation and/or improvement will normally not be considered for adjustment, as the provider's return from the Fair Rental payment has been designed to cover them. Any improvement and/or renovation with a cost in excess of five percent (5%) of the current asset value at the time of such improvement and/or renovation must be submitted

to Medicaid for review and adjustment to the current asset value, as appropriate. If a provider feels that a renovation or improvement not meeting the above requirements should be considered for an adjustment to the current asset value and interest base, as appropriate, they may request an exception to policy from Medicaid. Such consideration for exception will be limited to unexpected or unanticipated events, such as acts of nature or latent damages to the facility.

(11) Rebasing. The current asset value of all facilities participating in the Alabama Medicaid program will be rebased each year as of July 1. Rebasing will consist of adjusting the current asset value by indexing to reflect changes in construction cost. The Marshall-Swift Evaluation Service will be used to compute the change as of June 30 of each year. The index adjustment will be limited to no more than 3% each year.

(12) Depreciation. Depreciation expense on buildings, fixed equipment, and major movable equipment normally used in providing patient care and operation of a nursing facility will not be an allowable expense. The American Hospital Association publication, "Estimated Useful Lives of Depreciable Hospital Assets," will be used to determine the assets affected by this rule. Specialized equipment purchased by a facility for use in the treatment of heavy care patients will be depreciated over its useful life, and such depreciation expense will be an allowable cost for reimbursement. This equipment will be limited to those items listed in paragraph (19) below and the useful life indicated.

(13) Equipment Rental. Rental expense related to equipment normally used in providing patient care or operation of a nursing facility is not an allowable expense. Rental expense for specialized equipment acquired to treat heavy care patients will be allowed for reimbursement. This equipment will be limited to those items listed in paragraph (19) below.

(14) Insurance on Building and Contents. The reasonable costs of insurance on buildings and their contents used in the rendition of covered services purchased from a commercial carrier or a limited purpose insurer subject to the provisions of HIM-15, Section 2162(2) will be considered as allowable costs.

(15) Property Taxes. Ad Valorem and personal property taxes on property used in the rendition of covered services are allowable under this section. Fines, penalties, or interest related to those taxes are not allowable.

(16) Nursing Facility Privilege Tax. Taxes, interest and penalties established by Code of Ala. 1975, Section 40-26B-20, et seq., on nursing facility beds are allowable through December 31, 1992. Beginning January 1, 1993, such taxes are allowable. Interest and penalties related to these taxes are not allowable.

(17) Life and Rental Insurance. Premium payments for life insurance required by a lender or otherwise required pursuant to a financing arrangement will not be an allowable cost. Loss of rental insurance will also be considered an unallowable cost.

(18) Minor Equipment. Minor equipment purchases may be expensed and claimed for reimbursement. Minor equipment, for the purposes of reimbursement is any equipment that has a unit cost of $300 or less (beds, at any cost, are not to be reimbursed as minor equipment). Minor equipment expenses are to be included in the cost area in which the equipment is normally used. Group purchases of minor equipment, either in a single purchase or through periodic purchases throughout the reporting year, with an aggregate cost of $5,000 or more, must be capitalized and depreciated over the useful life of the assets. The depreciation expense must go on Schedule D, line 55-4 of the cost report.

(19) Expense related to the purchase and/or rental of the below listed items may be claimed by the provider in addition to the prevailing fair rental reimbursement. The provider shall maintain adequate records to substantiate any rentals, depreciation and interest expenses.

	Item	Life
1.	Feeding pump	10 years
2.	IPPB machine	5 years
3.	Ventilator	10 years
4.	Apnea monitor	5 years
5.	Oxygen Concentrator 3 Lpm.	5 years
6.	Oxygen Concentrator 5 Lpm.	5 years
7.	Oxygen nebulizer + heater	10 years
8.	Clinitron	15 years
9.	Aerosol machine without compressor	10 years
10.	Aerosol machine with compressor	10 years
11.	I vac pump	10 years
12.	ProCare System	3 years

This list is not intended to be all-inclusive. Additions will be made on an as needed basis. Requests for additions must be submitted to Chief Auditor, Provider Audit for approval. The amount of reimbursement will be determined by dividing the cost of rentals, depreciation, and interest incurred for equipment used by

Medicaid recipients by the reported Medicaid days. The resulting per diem will be added to the provider's property cost per diem.
Author: Sandra Johnson, Director, Provider Audit
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. Amended effective May 15, 1983; July 9, 1984; December 6, 1984. **Emergency rule** effective November 20, 1984. Amended effective February 8, 1985; June 10, 1987; November 17, 1987; March 12, 1988; May 12, 1989. **Emergency rule** effective May 1, 1990. Amended effective August 14, 1990; October 1, 1990. **Emergency rule** effectiveSeptember 12, 1991. Amended effective December 12, 1991; August 12, 1992. Emergency Rule effective July 1, 1993. Emergency Rule effective October 28, 1993 through December 31, 1993. This amendment effective December 14, 1993. **Amended:** Filed November 7, 1995 effective December 12, 1995. **Amended:** Filed December 8, 1997; effective January 12, 1998. **Amended:** Filed April 6, 1998; effective May 11, 1998. **Amended:** Published February 27, 2026; effective April 13, 2026.

560-X-22-.15 New Facility, Change In Ownership, Or Change In Category Of Care.

(1) A provider who constructs, leases, or purchases a facility, or has a change in category of care, can request reimbursement based on an operating budget, subject to the ceiling established under Rule 560-X-2-.05 of this chapter. In this event, the facility will be subject to a retroactive adjustment based on the difference between budgeted and actual allowable costs. These actual allowable costs will be reported on a complete interim cost report. If this interim report should span June 30, the Agency may accept this report as the interim and regular cost report. In this instance, the report will be used to settle the budgeted period and also to set the next year's prospective rate. If the Agency accepts this report as the June 30 regular report, the due date shall be September 15; if not, the due date will be 60 days after the end of the interim period as specified by the Agency.

(2) The difference between budgeted and/or projected costs in these instances will be subject to settlement within thirty (30) days after written notification by Medicaid to the provider of the amount of the difference.

(3) Upon voluntary or involuntary complete withdrawal of a facility participating in the Medicaid program, the provider will be subject to a retroactive adjustment based upon the difference between the amount of reimbursement paid by Medicaid and the actual allowable costs incurred by the former provider during the following periods:

(a) If the effective date of the withdrawal is less than six (6) months after the preceding July 1, a retroactive adjustment will be made for the current fiscal year and for the immediately preceding fiscal year.

(b) If the effective date of the withdrawal is six (6) months or more after the preceding July 1, a retroactive adjustment will be made for the current fiscal year only.

(4) Providers who terminate their participation in the Medicaid Program must provide a final cost report within seventy-five (75) days of terminating their participation in the program. Failure to file this final cost report will result in Medicaid treating all reimbursement for the period covered by the cost report as an overpayment.

(a) Terminating cost reports which are audited by the Agency will be subject to retroactive adjustment. This adjustment (if applicable) will either be paid or recouped by a lump sum payment.

(5)(a) Providers who change their category of care in the Medicaid Program must submit a final cost report for the previous category within seventy-five (75) days of notification from the Agency that a change in the category is authorized. Failure to file this final cost report will result in Medicaid treating all reimbursement for the period covered by the cost report (July 1 to the date of change in category) as an overpayment.

(b) Final cost reports, from the preceding July 1st to the date of change in category from the previous category, will be subject to retroactive adjustment. This adjustment (if applicable) will either be paid or recouped by a lump sum payment. Final cost reports will also be subject to audit by the Agency.

(6) In a transfer which constitutes a change in ownership, the old and new providers shall reach an agreement between themselves concerning trade accounts payable, accounts receivable, and bank deposits. Medicaid will pay the new provider for unpaid claims for services rendered both prior to and after the change of ownership. The new provider shall be liable to Medicaid for unpaid amounts due Medicaid from the old provider.

Author: Susan Mims

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.

History: Rule effective October 1, 1982. Amended effective July 9, 1984; December 6, 1984; August 9, 1985; May 15, 1990; October 1, 1990. **Emergency rule** effective September 12, 1991. Amended effective December 12, 1991.

560-X-22-.16 Return On Equity Capital.

Effective September 1, 1991, Return on Equity will no longer be used in rate computation. This does not relieve the provider of the responsibility of maintaining adequate records to account for receivables, prepaids, and payables.
Author: Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200- .272, et seq.
History: Rule effective October 1, 1982. Amended effective May 15, 1983; September 8, 1984; June 8, 1985; October 1, 1990. **Emergency rule** effective September 12, 1991. Amended effective December 12, 1991.

560-X-22-.17 Qualified Retirement Plans.

(1) The reasonable costs of funding "qualified" deferred compensation plans will be recognized as an allowable cost. "Qualified" deferred compensation plans means those plans which have been determined by the Internal Revenue Service to be qualified under Sections 401 or 405 of the Internal Revenue Code, as amended. Such plans can be generally categorized as either a defined benefit (hereinafter called "pension") or defined contribution (hereinafter called "profit-sharing") plan.

(2) Under a pension plan, the employer's contributions can be calculated based on the definitely determinable benefits provided for in the plan and such contributions are required without regard to the employer's profits. Pension plans typically provide that forfeitures resulting from termination of employees prior to their becoming one hundred percent (100%) vested in their account balance will be used to reduce further employer contributions, rather than being reallocated among the participants. The reasonable costs of a provider in funding such a pension plan will generally be considered as allowable costs, provided that the plan contains the usual provisions concerning use of forfeitures to reduce employer contributions (and therefore, Medicaid reimbursable costs). The portion of the provider's reimbursed costs under such plans which is attributable to the costs of funding the retirement benefits of employees whose compensation is includable in computing the administrative and management costs of this chapter will be considered as part of the compensation of each such employee during the year of contribution to the plan. For purposes of this chapter, money purchase pension plan requiring that all forfeitures be used to reduce current or future employer contributions rather than increasing the benefits payable to the participants will be subject to the provisions of this

paragraph relating to pension plans rather than the provisions relating to profit-sharing plans.

(3) A profit-sharing plan is a deferred compensation plan, under which the contributions are based upon the profits of the employer and frequently are completely discretionary with theemployer. Therefore, the contributions of the employer cannot be calculated based upon definitely ascertainable benefits to be provided to the employees. The employee, upon retirement, receives whatever amount is in his or her account on that date and is not guaranteed any certain level of retirement income.

(4) Under a profit-sharing plan, forfeitures created by employees terminating employment who are less than one hundred percent (100%) vested in their account balances are typically reallocated to the other participants (including those employees whose compensation falls within the administrative and management costs), rather than reducing further contributions by the employer. Therefore, the actual operation of such profit-sharing plans could result in a circumvention of the administrative and management cost center. Therefore, an employer's contributions to a profit-sharing plan will generally be considered a reimbursable cost for Medicaid purposes only if all amounts credited to the accounts of participants who are credited with more than three (3) years of service under the plan are nonforfeitable.

(5) As with pensions plans, all contributions to profit-sharing plans which are attributable to employees whose compensation is includable in computing administrative and management costs will be included in each such employee's compensation for the year during which the contribution is made to the plan for purposes of calculating the limitations imposed upon administrative and management costs under this Code. Provided, however, that in the event amounts attributable to previous Medicaid reimbursements are, under the "forfeiture" provisions of a profit-sharing plan, reallocated from the account of an employee not coming under the administrative and management cost limitations to the accounts of employees whose compensation is included in computing such limitations, such amounts will be includable in the compensation of the employees to whose accounts such amounts are credited for purposes of computing the administrative and management costs for the year of reallocation.

(6) Effective June 15, 1983, Medicaid will not recognize employee stock ownership plans or stock bonus plans that were not both in operation and approved prior to July 1, 1982.

(7) Other types of qualified retirement plans will be considered on a case-by-case basis by Medicaid utilizing the principles contained in this section to the extent that such principles are consistent with the nature of such plans.

(8) The accrual of costs by a provider under any unfunded deferred compensation arrangement will not be recognized as allowable costs for Medicaid reimbursement purposes.
Author: Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. Amended effective June 23, 1983; July 9, 1984; October 1, 1990.

560-X-22-.18 Costs To Related Parties.

(1) Allowable costs incurred by a provider for services or goods provided by related parties will not exceed the net cost of the services or goods to that related party, and that cost cannot exceed the fair market value of the items or services involved.

(2) The provisions of HIM-15 shall be applicable in determining whether a related party relationship exists.
Author: Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1 1982. Amended effective October 1, 1990. **Emergency rule** effective September 12, 1991. Amended effective December 12, 1991.

560-X-22-.19 Receipts Which Offset Or Reduce Costs.

(1) Certain income items or receipts must be used to either offset costs or reduce total reported costs. Typical, but not all inclusive, examples of such transactions are:

(a) Purchase discounts, rebates or allowances.

(b) Recoveries or indemnities on losses (i.e., insurance proceeds).

(c) Sale of scrap or incidental services.

(d) Sale of medical supplies (other than to patients).

(e) Medicare Part B - Income.

(f) Sale of meals.

(g) Cash contributions and donations designated by a donor for paying specific operating costs.

(2) These items may be handled in either of two ways, at the option of the provider:

(a) The cost related to the income can be offset. If this option is selected, the provider must maintain adequate records to support the amount offset.

(b) If all costs associated with the income cannot be or are not identified separately on the cost report and in the provider's books and records, then the total income must be used to reduce total reported costs.

(3) Cash contributions or donations which are not restricted or designated for a specific purpose by the contributor or donor are considered the property of the provider and can be used as they deem appropriate. This income does not have to be offset against any otherwise allowable cost. The provider, however, must keep adequate records to verify the source of such funds and lack of restriction.

(4) Interest earned on restricted funds such as mortgage escrow and/or deposits must be used to offset the interest expense incurred on those loans. Provider records must be adequate to allow verification of all such interest earnings.
Author: Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. Amended effective June 23, 1983; July 9, 1984. This amendment will apply for cost reports for the fiscal year ending June 30, 1985. Amended effective October 1, 1990. **Emergency rule** effective September 12, 1991. Amended effective December 12, 1991. **Amended:** Filed November 7, 1995 effective December 12, 1995.

560-X-22-.20 Chain Operations.

(1) A chain organization consists of a group of two or more nursing facilities which are owned, leased, or through any other device controlled by related organizations or individuals. The home office of a chain organization is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The home office organization will be treated as a "related party" to participating nursing facilities for purposes of this chapter. Only the home office's actual cost of providing management services is permitted to be allocated to the providers and then only to the extent that they do not duplicate servicesalready provided in the nursing facility. Costs that would not be allowable if directly claimed by a provider will not be allowed as an allocation from a home office.

(2) It is not considered appropriate for the taxpayers of Alabama to pay more for the operation of a nursing facility owned or operated by a chain than would be paid for an individually operated nursing facility. A chain operated facility is expected

to be more efficient and economical to operate than an individually operated facility.

(3) If a home office provides centralized laundry, maintenance, and purchasing services to facilities, the actual costs of providing these services will be charged to the facilities to which the services are provided. The facility will report these costs in the appropriate cost center on its cost report.

(4) Maintenance, Central Purchasing, and Laundry.

(a) Examples of home office costs associated with providing these services include:

1. Maintenance (Plant Operations Cost Center):

(i) Salaries and Benefits.

(ii) Supplies.

(iii) Materials.

(iv) Travel expense subject to limitations contained in Rule 560-X-22-.13.

2. Central Purchasing (Reported as Other Allowable in lieu of a group purchasing fee):

(i) Salaries and Benefits.

(ii) Goods.

(iii) Supplies.

(iv) Materials.

(v) Travel expense subject to limitations contained in Rule 560-X-22-.13.

(vi) Building Costs:

(I) Insurance.

(II) Rent.

(III) Lease.

(IV) Utilities.

(V) Depreciation.

(VI) Interest.

3. Laundry (Laundry Cost Center):

(i) Salaries and Benefits.

(ii) Supplies.

(iii) Materials.

(iv) Travel expense subject to limitations contained in Rule 560-X-22-.13.

(v) Building costs:

(I) Insurance.

(II) Rent.

(III) Lease.

(IV) Utilities.

(V) Depreciation.

(VI) Interest.

(b) Allowable salaries and benefits for these services will be limited to persons directly involved in performing such services. Allowable costs, as defined in this section, which can be identified to a specific member of the chain will be directly allocated to the proper cost center of that facility. The allowable costs not directly allowable should be allocated among the providers (and to any nonprovider activities in which the home office may be engaged) on a basis designed to equitably allocate the costs over the chain components or activities receiving the benefits from the costs and in a manner reasonably related to the services received by the entities in the chain. The costs of allocated building space must be used exclusively for these purposes and based on percentage of usage of totalsquare feet. If a separate building is utilized, separate utility meters must be utilized.

(5) Administrative Costs. All costs incurred in maintaining a home office other than maintenance, laundry, purchasing, and corporate nurse costs will be classified as administrative and management costs and will be subject to the limitations contained in Rule 560-X-22-.10. Allocation of these costs to a facility will be on the basis of patient days. Home offices will report their allocation on lines 5-1 (Salary), 5-2 (Benefits), and 5-17 (Other) on Schedule D of the Uniform Cost Report.

(6) Equity Capital See Rule 560-X-22-.16.
Author: Susan Mims

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. Amended effective May 15, 1983. This amendment will apply for cost reports for the fiscal year ending 6-30-83. Amended effective October 1, 1990. **Emergency rule** effective September 12, 1991. Amended effective December 12, 1991.

560-X-22-.21 Cost Allocation.

(1) Multiple use facilities, such as hospital-nursing facilities or retirement home-nursing facilities, will allocate all allowable costs which are not directly associated with a specific revenue producing department.

(2) Examples of costs which are usually allocated include, but are not limited to:

(a) Depreciation.

(b) Administrative and General.

(c) Employee Health and Welfare.

(d) Plant Operations.

(e) Laundry and Linen.

(f) Housekeeping.

(g) Medical Records.

(h) Dietary.

(i) Social Services.

(j) Pharmacy.

(3) Examples of revenue-producing departments are:

(a) Retirement Home.

(b) Nursing Facility.

(c) Hospital Facility.

(4) Certain cost items must be identified and allocations of those items to various cost centers must be adjusted so that the total cost allocated will be reported on the specific cost report lines as applicable. These costs are:

(a) Medical Records Cost.

(b) Consultant Fees.

(c) Medical Directors Fees.

(d) Depreciation Expense.

(e) Interest Expense.

(f) Property Taxes & Insurance.

(g) Raw Food.

Author: Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. Amended effective October 1, 1990. **Emergency rule** effective September 12, 1991. Amended effective December 12, 1991.

560-X-22-.22 Unallowable Expenses.

(1) General:

(a) All payments to providers for services rendered must be based on the reasonable cost of such services covered by the Alabama State Plan. It is the intent of the program that providers will be reimbursed the reasonable costs which must be incurred in providing quality patient care. Implicit in the intent that reasonable costs be paid are the expectations that the provider seeks to minimize costs and that costs do not exceed what a prudent and cost-conscious buyer pays for a given item of service or product. If costs are determined to exceed the level that prudent buyers incur in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not allowable.

(b) Costs related to patient care include necessary and proper costs involved in developing and maintaining the efficient operation of patient care facilities. Necessary and proper costs related to patient care are those which are usual and accepted expenses of similar providers.

(2) Costs Covered by Other Programs. Costs that are covered by other state and/or federal programs will not be allowed, and costs which are covered by other Alabama Medicaid Agency programs will not be reimbursed under the nursing home program. Examples of such costs include, but are not limited to:

(a) Prescription Drugs.

(b) Dental Expense (except consultant fees).

(c) Physicians' Fees other than those required by licensure.

(d) Laboratory Expense for Patients.

(e) Oxygen (except for concentrators).

(f) Ambulance Service.

(g) Inhalation Therapy.

(h) Group Therapy.

(i) Medicare Part B Supplies.

(3) Administrative Costs. Items of administrative costs which will not be allowed are listed below. This listing is not intended to be all inclusive. Other administrative costs which violate the prudent buyer concept or are not related to patient care will not be reimbursed by the Alabama Medicaid Agency.

(a) Management Fees: Management firms, individuals and consultants which duplicate services already provided, or in a facility in which a full-time licensed administrator is employed: Excluded from this rule are those management contracts required incident to a bond issue for a valid business purpose.

(b) Director's Fees and Other than Nominal Meeting Expenses.

(c) Compensation to owners and other personnel not performing necessary functions (See Rule 560-X-22-.10).

(d) Salaries which are paid to personnel performing overlapping or duplicate functions.

(e) Legal Fees and Expenses:

1. Retainers.

2. Relating to informal conference and fair hearings.

3. Relating to issuance and sale of capital stock and other securities.

4. Relating to creation of corporations or partnerships.

5. Relating to business reorganization.

6. Services for benefits of stockholders.

7. Acquisition of nursing facilities or other business enterprises.

8. Relating to sale of nursing facilities and other enterprises.

9. In connection with criminal actions resulting in a finding of guilt or equivalent action or plea.

10. Other legal services not related to patient care.

(f) Outside Accounting and Audit Fees and Expenses:

1. Personal tax returns.

2. Retainers.

3. Relating to informal conferences and fair hearings.

4. Relating to issuance and sale of capital stock and other securities.

5. Relating to creation of corporations or partnerships.

6. Relating to business reorganization.

7. Services for the benefits of stockholders.

8. Acquisition for nursing facilities or other business enterprises.

9. Relating to sale of nursing facilities and other enterprises.

10. In connection with participation in criminal actions resulting in guilt or equivalent action or plea.

11. Feasibility studies related to acquisition costs obtained after 10/1/84 (See Rule 560-X-22-.14(9)(g).

12. Other Accounting services not related to patient care.

(g) Taxes:

1. Personal income.

2. Property not related to patient care.

3. Corporate income tax.

4. Vehicle tag & tax.

(h) Dues:

1. Club.

2. Civic.

3. Social.

4. Professional organization dues for individuals unless employment of individual negates need for qualified consultants.

5. Nonpatient care related organization:

(i) Insurance:

1. Life.

2. Personal property not used in patient care.

3. On real estate not used in providing patient care.

4. Group life and health insurance premiums which favor owners of a provider or are for personnel not bona fide employees of the facility.

(j) Advertising in excess of the limitations of Rule 560-X-22-.10.

(k) Chaplains/Spiritual Advisors.

(1) Special assessments from Nursing Home Association.

(m) Bad debts and associated collection expenses.

(n) Employment Agency/Employee Search Fees for other than Administrator and direct care personnel.

(o) Employees relocation expenses.

(p) Penalties:

1. Late Tax.

2. Late payment charges. (Note: If a facility can fully document that a late payment charge is directly due to late Medicaid payments, the amount of the late payment charge will be an allowable cost.)

3. Bank overdraft.

4. Fines.

(q) Certain Real Estate Expenses:

1. Appraisals obtained in connection with the sale or lease of a nursing facility (unless required by Medicaid).

2. Costs associated with real estate not related to patient care.

(r) Interest Expense:

1. Interest associated with real estate in excess of nursing facility needs or real estate not related to patient care.

2. Interest paid to unrelated parties on working capital loans will be limited to no more than 90 days interest on an amount not in excess of two months average allowable cost per cost reporting period.

3. Interest expenses applicable to penalties.

4. Construction Interest (must be capitalized).

5. Interest paid to a related party.

6. Interest on personal property not related to patient care.

7. Interest on loans not associated with patient care.

8. Interest expense generated by the refinancing of any long-term debt that exceeds the amount which would have been allowed had refinancing not occurred unless such excess interest meets the necessary and reasonableness tests of Rule 560-X-22-.11(1).

(s) Licenses:

1. Consultants.

(t) Donations and Contributions.

(u) Accreditation Surveys.

(v) Telephone Services:

1. Mobile telephones, beepers, (except for directors of nursing or maintenance personnel), telephone answering and recording devices, telephone call relays, automated dialing services, and off-premise telephones.

2. Long distance telephone calls of a personal nature.

(w) Organizational and Start-up Costs - All costs related to the issuance and sale of shares of capital stock, including underwriters' fees and commissions, accounting or legal fees incurred in establishing the business organization, costs of qualifying with the appropriate federal or state authorities, stamp taxes, etc., expenses of temporary directors, costs of organizational meetings of directors and/or stockholders, incorporation fees.

(x) Any costs associated with corporate stock records maintenance.

(4) Prior Period Costs and Accounts Payable:

(a) The Medicaid reimbursement rate is calculated to provide adequate funds to pay business expenses in a timely manner. Costs incurred in prior periods but not paid must be accrued and reported in that period during which the costs were incurred. Payment of prior period cost in the current year is not an allowable cost. Exceptions will be allowed, based on reasonableness, for small invoices which, in total, do not exceed $500 per fiscal period. These invoices must be as a result of no fault of the provider. Any pattern of abuse will cause the costs in question to be automatically disallowed by the Agency.

(b) Short-term liabilities must be paid within ninety (90) days from the date of invoice; otherwise, the expense will not be allowed unless the provider can establish to the satisfaction of Medicaid that the payment was not made during 90 days for a valid business reason.

(c) Actual payment must be made by cash or negotiable instrument. For this purpose, an instrument to be negotiable must be in writing and signed, must contain an unconditional promise or order to pay a certain sum of money on demand or at a fixed and determinable future time, and must be payable to order of or to bearer. All voided instruments, whether voided in fact or by devise, are considered void from inception.

(d) A provider who files for and is awarded protection under Chapter 11 of the Federal Bankruptcy Code may be given consideration in a current year cost report for actual payment of prior period allowable costs which have been disallowed in prior period cost reports due to failure to make actual payment of the cost claimed. In order for payment of these prior year allowable costs to be considered under a current year cost report, they must have been paid pursuant to a court approved plan for reorganization under Chapter 11 of the Federal Bankruptcy Code. The allowable costs will not include any interest or penalty incurred for failure to make payment in the prior year. The Agency will not reimburse interest expense generated from loans incurred to pay any such

allowable prior period costs. Any such (untrended) allowable cost per day shall be added to the per diem rate after the normal rate setting process. It will be subject to the various cost ceilings, thus the provider's cost must be below the ceilings for any possible reimbursement of these prior period costs to occur.

(5) Noncovered Services:

(a) The costs of providing personal services and costs associated with income producing activities are not allowable and must be eliminated from cost. If all costs associated with the service or activity cannot be, or are not identified separately on the cost report, then the total income which was generated must be used to offset total reported costs.

(b) Examples of these services or activities are laundry and dry cleaning of personal apparel (subject to the provisions of Rule 560-X-22-.12), radio, television, telephone, and vending machines.

(c) The following are examples of costs associated with noncovered services or activities which are not reimbursable:

1. Materials or goods.

2. Supplies.

3. Salaries and Employee Benefits.

4. Applicable Fair Rental payment.

(6) Beauty and Barber Services:

(a) If the nursing facility makes no charge to the patient for beauty and barber services, and if this service is performed by employees of the facility or by volunteers, then the costs associated with the service are allowable for Medicaid reimbursement purposes.

(b) If the nursing facility makes a charge to the patient for beauty and barber services and if all costs associated with the service or activity cannot be, or are not identified separately on the cost report, then the total income which was generated from the service must be used to reduce or offset total reported costs.

(7) Miscellaneous or Other Nonallowable Expenses. The following is a list of expenses which have previously been submitted in cost reports that are unallowable. It is intended to typify unallowable transactions and is not intended to be all-inclusive:

(a) Nursing consultants, except those required by OBRA 87 requirements.

(b) Additional wages paid as a result of an audit by the Wage and Hour Administration which relate to a prior period. However, additional payments made as the result of workman's compensation audits conducted after the end of the relevant fiscal year will be considered allowable costs for the fiscal year in which such payments are made.

(c) Newspaper or magazine subscriptions in excess of $250.

(d) Off-premise telephone service.

(e) Farm expense.

(f) Real estate costs associated with real estate ownership in excess of nursing facility needs and not related to patient care.

(g) Sitter services or private duty nurses.

(8) Gifts. The cost of gifts made by a provider in excess of $20.00 per bona fide facility employee per fiscal year is an unallowable expense.

Author: Sandra Johnson, Director, Provider Audit
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
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560-X-22-.23 Cost Reports.

(1) Extensions. Each provider is required to file a complete uniform cost report for each fiscal year ending June 30th. The complete uniform cost report must actually be received by Medicaid on or before September 15. Should September 15 fall on a state holiday or weekend, the complete uniform cost report will be due the next following working day. Cost reports shall be prepared with due diligence and care to prevent the necessity for later submittals of corrected or supplemental information by the nursing facility. Extensions may be granted only upon written approval by Medicaid for good cause shown. An extension request must be in writing, contain the reasons for the extension, and must be made prior to the cost report due date. Only one extension per cost reporting year will be granted by the Agency. Extensions in excess of thirty (30) days will not be granted. For cost reports due

September 15, 1991 and 1992, extensions of onlyfifteen (15) days will be authorized, but only in cases of extreme hardship.

(2) Penalties. If a complete uniform cost report is not filed by the due date, or an extension is not requested or granted, the provider shall be charged a penalty of one hundred dollars per day for each calendar day after the due date; this penalty will not be a reimbursable Medicaid cost. The Commissioner of Medicaid may waive such penalty for good cause shown. Such showing must be made in writing to the commissioner with supporting documentation. Once a cost report is late, Medicaid shall suspend payments to the provider until the cost report is received. A cost report that is over ninety (90) days late may result in suspension of the provider from the Medicaid program. Further, the entire amount paid to the provider during the fiscal period with respect to which the report has not been filed will be deemed an overpayment. The provider will have thirty (30) days to either refund the overpayment or file the delinquent cost report after which time Medicaid may institute a suit or other action to collect this overpayment amount or the delinquent cost report.

(3) Each uniform cost report will be signed by the provider, and if the cost report is prepared by anyone other than the provider or a full-time employee of the provider, such person shall execute the report as the cost report preparer. The signatures of both the provider and cost report preparer, if any, must be preceded by the following certification: I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared on behalf of

_____

[Provider name(s) and number(s)]

for the cost report period beginning and ending_____, and that to the best of my knowledge and belief, it is a true, correct, and report prepared from the books and records of the provider(s) in accordance with applicable Medicaid reimbursement principles, except as noted.

Signed _____

Officer or Administrator of Provider(s)

_____

Cost Report Preparer

By: _____ _____

Title

_____

Date

(4) Any cost report received by Medicaid without the required original signatures and/or without the required certification(s) will be deemed incomplete and returned to the provider.

(5) Cost reports should be prepared with due diligence and care to prevent the necessity for later submittals of corrected or supplemental information by providers. Cost reports will be deemed immutable with respect to the reimbursement for which the provider is entitled for the next succeeding fiscal year, one year from the date of its receipt by Medicaid, or its due date, whichever is later. Providers will have this one year period within which to resubmit their cost reports for the purpose of correcting any material errors or omissions of fact. This one year limitation does not apply to adjustments in cost reports that are initiated by Medicaid. Medicaid retains the right to make adjustments in cost reports at any time a material error or omission of fact is discovered.

(6) Providers who terminate their participation in the Medicaid program, by whatever means, must provide a written notice to the Agency thirty (30) days in advance of such action. Failure to provide this written notice shall result in a one hundred dollar ($100) per day penalty being assessed for each day short of the 30-day advance notice period (up to a maximum of $3,000). Terminating providers must file a final cost report within seventy-five (75) days of terminating their participation in the program. Final payment will not be made by the Medicaid Agency until this report is received. Failure to file this final cost report will result in Medicaid deeming all payments covered by the cost report period as overpayments until the report is received. Additionally, a penalty of one hundred dollars ($100) will be assessed for each calendar day that the cost report is late.
Author: Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. **Amended:** effective July 9, 1984; June 10, 1987; July 12, 1988; February 13, 1990; October 1, 1990. **Emergency rule** effective September 12, 1991. Amended effective December 12, 1991.

560-X-22-.24 Accounting Records.

(1) The provider must submit adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be presented on the accrual basis of accounting. This basis requires that revenuemust be allocated to the accounting period in which it is earned and expenses must be charged to the period in which they are incurred, regardless of when cash is received or disbursed.

(2) Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for supplies, services, or assets. This includes all ledgers, books, records, and original evidence of costs which pertain to the costs reported. Financial and statistical records should be maintained in a consistent manner from one period to another; however, the regard for consistency should not preclude a desirable change in accounting procedures provided that full disclosure of significant changes is made.

(3) The following records and documentation must be kept by the provider and must be available for audit inspection by Medicaid:

(a) General Ledger.

(b) Disbursements Journal.

(c) Cash Receipts Journal.

(d) Payroll Journal.

(e) Working Trial Balance and Adjusting Entries.

(f) Patients Personal Funds Records.

(g) Patient Admission and Discharge Records.

(h) Purchases Journal (For facilities larger than 100 beds).

(4) All information contained in the provider's general ledger must be capable of audit verification. Disbursements must be supported by invoices which detail the quantity and price of goods and services purchased, together with evidence that such goods and/or services were received. Disbursements made without proper documentation will not be allowable for Medicaid reimbursement purposes. This documentation should be filed in chronological order, either alphabetically or in some other reasonable manner capable of being audited. Payroll journals must be supported by time cards or other documentation signed by the employee and verified by his/her department head. Each time card or other documentation must also indicate the hours worked by the employee, the rate of pay for the services rendered by the employee, and must be identified by the cost center, to which the expense should becharged. If an employee works in more than one area, the expense should be charged to more than one cost center, and the expenses should be allocated to the centers in the same ratio as the work is performed, with a notation made to explain the allocation.

(5) Subsidiary records which must be kept by the provider and be readily available for audit and inspection include, but are not limited to:

(a) Accounts Receivable ledger sheets or cards which agree with the general ledger control account (to include June 30 aging schedules).

(b) Accounts payable ledger sheets or cards which agree with the General Ledger control accounts (to include June 30 aging schedules).

(c) Notes Receivable.

(d) Notes Payable.

(e) Long-Term Debt evidenced by amortization schedules and copies of the original debt transaction.

(f) Insurance policies together with invoices covering the fiscal year reported.

(g) Depreciation Schedules showing the cost of the facility and equipment.

(h) Payroll Tax Returns.

(i) Income Tax Returns.

(j) Census Records (See Schedule 8-A).

(k) Bank Statements, cancelled checks, deposit slips, voided checks, and bank reconciliations.

(l) A signed copy of the current lease.

(m) Automobile travel logs.

(6) Petty cash funds shall be maintained under the Imprest System. The disbursement of these funds shall be substantiated by an invoice and/or voucher detailing the date of disbursement, expense category, and name of person disbursing the funds.

(7) All documents, work papers, and schedules prepared by and on behalf of the provider which substantiate data in the cost reports must be made available to Medicaid auditors and investigators upon request.

(8) The provider will provide adequate desk space and privacy to Medicaid auditors and investigators during the progress of audits. The provider's personnel or personnel representing an outside independent accountant may be present at a Medicaid audit and be allowed access to the Medicaid auditors and workpapers only at the invitation and discretion of the Medicaid auditors during the course of their work at the provider's establishment.

(9) In the event a Medicaid auditor or investigator is denied access to a nursing facility's provider's records, the provider will be advised of the contract provisions governing inspection and review of these records by authorized representatives. The provider will be advised that if access to records is not granted, the provider will be given ten (10) calendar days in which to furnish the records to Medicaid at its Montgomery offices. If a provider fails to comply within the ten (10) day period, Medicaid will reduce all subsequent reimbursement payments by the costs it has been unable to substantiate.

(10) If the provider fails to keep the minimum financial records required to properly substantiate reported costs, the provider will be in violation of the provider agreement and will be subject to termination from the Medicaid program.

(11) All books and records required to be kept and made available to Medicaid personnel by a provider will be made available at the nursing facility unless this requirement is specifically waived in writing in advance by Medicaid.

(12) If a provider who has been given three (3) full working days' notice of an audit fails to make the required records, including any not maintained at the facility, available at that facility, the Medicaid auditor(s) will return to his (their) office, and the provider will be given ten (10) calendar days to present all of the accounting records at the Medicaid office. Should the provider fail to present all of the accounting records at the Medicaid office during the allotted time period, Medicaid will consider all payments made to the provider during the time period covered by the records sought to be audited to be overpayments and may proceed to recover those overpayments from the provider.

(13) If Medicaid is required to go out of state for an audit, the organization being audited will bear all expenses and costs related to the audit, including, but not limited to, travel and reasonable living expenses, and those costs will not be allowable on any subsequent cost report.

Author: Susan Mims

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.

History: Rule effective October 1, 1982. Amended effective July 9, 1984; October 1, 1990.

560-X-22-.25 Patient Personal Fund Accounts.

(1) Personal Fund Management. In accordance with federal regulations for Medicare and Medicaid facilities, a medical assistance patient may manage his personal affairs unless a facility accepts the patient's delegation of this responsibility.

A patient managing his personal affairs may voluntarily have a facility hold custody of his funds.

(2) Voluntary Patient Delegation of Responsibility to the Facility. There are three (3), and possibly more, specific categories of Medical Assistance patients who may voluntarily delegate to the facility the management of personal financial affairs:

(a) Persons receiving social security checks or other income which is applicable under medical assistance to the cost of services less a thirty dollar ($30.00) per month personal care allowance.

(b) Persons receiving a check from the Department of Human Resources for a twenty-three dollar ($23.00) per month personal care allowance.

(c) Persons receiving donated funds from their family or friends which are not applicable to the cost of services. In the event these persons voluntarily delegate the management or custody of such funds to the facility, proper management and accountability for the funds must be provided by the facility.

(3) Establishment of a General Patient Fund Account:

(a) All patient funds for which the facility has accepted delegation or legal responsibility will be maintained in a separate General Patient Fund Account, which may also include the funds of persons who are not under the Medical Assistance Program.

(b) Receipts, disbursements, and earned interest will be debited and credited to this account. The separate account is required to assure that personal funds of patients are not commingled with other facility accounts and records. Maintenance of the personal fund account is considered to be a normal function of the administrative staff, and no additional personnel will be authorized for reimbursement purposes.

(c) The facility must purchase a surety bond to guarantee the security of all personal funds of residents entrusted to the institution.

(4) Endorsements, Receipts, and Deposits. The facility shall present checks or other receipts for moneys to the patient for his personal endorsement prior to depositing them in the facility's general patient fund account. If funds received by the facility do not require endorsement, the facility will ensure that all such funds are properly posted in the individual patient subsidiary ledger. Unless prior written authorization is given by the patient or his/her guardian, a voucher or other form of documentation

showing the date, amount, and proper authorizing signature for each transaction shall be retained by the facility.

(5) Expenditure of Funds from the General Patient Fund Account:

(a) A facility may not use a medical assistance patient's personal funds to supplement a payment for nursing care. A facility that fails to comply with this regulation will be subject to prosecution under federal and state laws.

(b) Also, a facility may not bill a patient for undelivered personal services such as manicures, haircuts, hair styling, laundry, and dry cleaning.

(c) The facility may not automatically use the patient's funds as a partial or complete payment to the facility for noncovered services such as laundry or beauty/barber services. Before such use can be made of these funds, the facility must have the written consent of the patient or his/her legal guardian.

(d) Within thirty (30) days after discharge or transfer of the patient to another facility, all remaining funds for the patient shall be returned by check to the patient or the patient's legally responsible relative or legal guardian.

(e) In case of death, all remaining funds shall be returned by check to the patient's estate. If there are no knownheirs or estate, the facility may turn over these funds under the provisions of the Uniform Disposition of Unclaimed Property Act, (Code of Ala. 1975, §§35-12-20 through 35-12-48) by filing the appropriate forms (UP-1, UP-2), along with the properly identified funds to the Alabama Department of Revenue, Unclaimed Property Section. The forms may be obtained from the Alabama State Revenue Department. Proper delivery of funds under the terms of the above statute relieves the facility of liability for such funds.

(6) Accounting Records to be Maintained. A facility shall maintain the following records relative to the receipt and expenditure of a Medical Assistance patient's funds:

(a) General Patient Fund Account:

1. The facility shall maintain a separate accounting record for the General Patient Fund Account. This accounting record may be maintained in the general ledger. The total of all patient's funds shall be reflected in this account, except funds transferred to a savings account.

2. The total patient's funds record shall be reconciled to the bank statement each month.

(b) Individual Patient Subsidiary Ledger:

1. An Individual Patient Ledger, which may be a card or computer record, shall be maintained for each medical assistance patient for whom the facility has accepted the responsibility for personal funds. If a computer record is maintained, a quarterly printout is required and should include the same information as is required on the card.

2. The medical assistance patient's full name and Medicaid number are to be entered on the form. All deposits and disbursements are to be recorded in chronological order.

(c) General Ledger Interest Bearing Account of Total Patient Funds:

1. The facility must deposit in a federally insured interest bearing account all funds in excess of $50.00 per recipient. Amounts less than $50.00 per patient may be maintained in either a petty cash fund or a noninterest bearing account.

2. An account of the total amount of patient's funds is to be maintained by the facility.

3. The facility may use interest earned on patient funds to meet the costs of maintaining the patient funds. If, however, the interest earnings are less than the maintenance charges (charges imposed by the bank) the facility may not use patient funds to cover the difference.

4. Interest as earned must be posted to each resident's account upon notification by the financial institution of such earnings as appropriate. Earned interest will not be spent for patient care or services required to be provided by the facility under federal and state regulations.

(d) Petty Cash Fund Records:

1. Facilities that maintain a petty cash fund to disburse small amounts of money to patients shall credit the total withdrawal of such funds to the General Patient Fund Account described previously.

2. When the petty cash fund is replenished, the amounts of the disbursements shall be posted to the Individual Patient Subsidiary Ledger.

(e) Inadequate Records. When individual patient subsidiary ledgers or records do not reconcile with the Patient Personal Fund bank accounts and/or control account, the patient's funds are commingled with facility funds, or when any other situation exists in which auditors are unable to determine correct balances and/or separation of the patient personal funds, an income offset adjustment for any difference shall be made against other allowable reported costs of the provider. The adjustment (if any) will be determined during the course of an audit in accordance with generally accepted accounting principles and auditing standards.

(f) When the balance in a Medical Assistance patient's personal fund account accumulates to within $200 of the resource limit as established by Medicaid, the facility must give written notice to the patient and/or his/her legal guardian of the possibility of losing Medicaid eligibility and the options available to him.

(7) Reporting of Patient's Funds Quarterly Report to patient. In accordance with federal regulations, at least once every three (3) months, the facility will give the patient, or the patient's legally responsible relative or legal guardian, a copy of the Individual Subsidiary Patient Ledger Card or computer printout listing all deposits, disbursements, and the current balance.
Author: Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. Amended effective August 10, 1983. **Emergency rule** effective July 1, 1988. Amended effective July 12, 1988; May 15, 1990; October 1, 1990.

560-X-22-.26 Audit Adjustment Procedures.

(1) Audit adjustments will be paid or collected by a combination of (1) changing the per diem rate of the facility and (2) a lump sum settlement for the amount under/over paid for the period prior to the effective date of the per diem rate change.

(2) Under/Overpayment situations arising from the audit of a terminating cost report will be paid or recouped by a lump sum settlement.

(3) All adjustments will be subject to the limitations set out in this chapter and subject to the appropriate ceilings.

(4) Collection procedures will be applied only after the facility has been given thirty (30) days in which to disagree with any of the disallowances contained in the report of audit.

(5) A final audit computation sheet [See Schedule 26-A at end of chapter] will be forwarded to each facility with the report of audit. An adjusted per diem rate will be stated in the report of audit and will be computed based on the audit adjustment. This new per diem rate will be effective for billing purposes on the 1st day of a month, allowing for the thirty (30) day notification period and a reasonable amount of time for processing the report of audit. The effective date of the rate change will be shown in Item I of the final audit computation worksheet. The remaining portion of the audit settlement will be collected or paid in a lump sum amount as shown in the final audit computation sheet for items II, III, and IV. This lump sum amount for the months prior to the effective date (underpayment or overpayment period) of the rate change is computed by applying the adjustment per patient day (Part II) to the total Medicaid days in the overpayment/ underpayment period (Part III, e). The lump sum amount due to the provider or Medicaid is shown on the last item in Part IV.
Author: Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. Amended effective December 6, 1984; October 1, 1990.

560-X-22-.27 Appeals.

(1) Facility administrators who disagree with the findings of the Medicaid desk audits or field audits may request, in writing, an informal conference at which they may present their positions. Such written requests must be received by Medicaid within thirty (30) days of the date on which Medicaid mails the audit report, or new reimbursement rate, as the case may be, to the provider.

(2) Administrators who believe that the results of the informal conference are adverse to their facility may ask, in writing, for a fair hearing, which will be conducted in accordance with Medicaid regulations. Such written requests must be received by Medicaid within fifteen (15) days of the date on which Medicaid mails to the provider its determination on the issues presented at the informal conference.
Author: Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. Amended effective October 1, 1990. **Emergency rule** effective September 12, 1991. Amended effective December 12, 1991.

560-X-22-.28 Negligence Penalty.

(1) Whenever an overpayment of Medicaid reimbursement received by a provider from Medicaid results from the negligence or intentional disregard of Medicaid Reimbursement Principles by the provider or its representatives (but without intent to defraud), there will be deducted from any reimbursement thereafter due the provider a penalty equal to 5% of such overpayment.

(2) If any part of such an overpayment by Medicaid to the provider is due to fraud on the part of the provider or any of its representatives, there will be deducted from any subsequent reimbursement due the provider on proof of fraud, a penalty equal to 50% of the overpayment.

(3) The penalties imposed under Rule 560-X-22-.28(1)(2) shall be in addition to and shall in no way affect Medicaid's right to also recover the entire amount of the overpayment caused by the provider's or its representative's negligence or intentional disregard of the Medicaid Reimbursement Principles or fraud.

(4) Whenever the cost of a good or service has been previously disallowed as the result of a desk audit of a provider's cost report and/or a field audit by Medicaid and such cost has not been reinstated by voluntary action of Medicaid, as the result of an administrative hearing, or by a court order, such costs shall not thereafter be included as an allowable cost on a Medicaid cost report. The inclusion by the provider or its representative of such a cost on a subsequent cost report, unless the provider is actively pursuing an administrative or judicial review of such disallowance, will be considered as negligent and/or intentional disregard of the Medicaid Reimbursement Principles and subject to the 5% penalty imposed by Rule 560-X-22-.28(1) based upon the amount of overpayment which has or which would have resulted from the inclusion of such cost had its inclusion not been detected. Such inclusion shall also be subject to the provisions of Rule 560-X-22-.29 relating to intentional or negligent disregard of the Medicaid Reimbursement Principles.

(5) For purposes of the preceding paragraph, a provider shall be considered as having included a previously disallowed cost on a subsequent year's cost report if the cost included is attributable to the same type good or service under substantially the same circumstances as that which resulted in the previous disallowance. Examples of such prohibited inclusions include, but are not limited to:

(a) Inclusion of the Portion of rental payment previously disallowed as being between related parties.

(b) Inclusion of an amount of compensation which has previously been disallowed as unreasonable during a prior period.

(c) Inclusion of a cost not related to patient care which has previously been disallowed.

(d) Improper classification or allocation of costs to cost centers.

(6) Rule 560-X-22-.28(4) shall NOT be interpreted as indicating that a provider's or his representatives initial entry of a cost item on a cost report will not be treated as a negligent or intentional disregard of the Medicaid Reimbursement Principles.

(7) Any provider who knowingly files or allows to be filed a cost report which has been prepared by a person who has been suspended as a cost report preparer during his period of suspension, shall be subject to termination of its provideragreement, and, in addition, subsequent reimbursement otherwise due the provider shall be reduced by $1400, as though the cost report had not been received by Medicaid during the fourteen (14) day period following the due date for filing such report. (See 560-X-22-.23.)

(8) Providers and their representatives who are uncertain as to whether the inclusion of a cost in a cost report is in violation of the Medicaid Reimbursement Principles should footnote or otherwise call attention to the entry in question and specifically disclose the dollar amount and the portion of the cost report entry as to which they are in doubt.
Author: Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§ 447.200 - .272, et seq.
History: Rule effective October 1, 1982. Amended effective October 1, 1990.

560-X-22-.29 Cost Report Preparers.

(1) Cost Report Preparers. "Cost Report Preparer" includes any person (including a partnership or corporation) who, in return for compensation, prepares or employs another to prepare all or a substantial portion of a Medicaid cost report. A cost report preparer can include both the actual preparer of the report as well as his or her employer. Where more than one person aids in filling out a Medicaid cost report, the one who has primary responsibility for the preparation of the report will usually be a preparer, while those involved only with individual portions of the report will usually not be preparers. Any person who supplies enough information and advice so that the actual completion of the return is a mere mechanical or clerical matter is a cost report

preparer even though the person doesn't actually place or review the placement of the information on the cost report.

(2) Refusal of Cost Reports. Medicaid will refuse to accept cost reports prepared by a cost report preparer who:

(a) Has shown a pattern of negligent disregard of the principles established by or incorporated by reference into this Code;

(b) Prepares a cost report evidencing an intentional disregard of the Medicaid Reimbursement Principles;

(c) Has given false or misleading information, or participated in giving false or misleading information to anyMedicaid employee, the Alabama Medicaid Agency, or to any hearing officer authorized to conduct hearings with regard to Medicaid reimbursement issues, knowing such information to be false or misleading. "Information" includes facts or other information contained in testimony, Medicaid Cost Reports, financial statements, affidavits, declarations, or any other documents or statements, written or oral.

(d) Medicaid will treat any cost report prepared by a cost report preparer who has been determined to be ineligible to prepare Medicaid cost reports as incomplete and shall promptly return any such cost report to the provider on whose behalf the report has been prepared. The receipt by Medicaid of such cost reports shall not satisfy, suspend, or stay the requirements of this chapter relating to the timely filing of Medicaid Cost Reports.

(3) Determination of Eligibility:

(a) Upon receipt by any Medicaid employee of information indicating that a cost report preparer may have engaged in conduct which could result in the refusal by Medicaid to accept cost reports prepared by such preparer under 560-X-22-.29(2) of this section, such information shall be promptly reported to Medicaid's Director of Provider Audit who shall ensure that an informal inquiry is made regarding the reliability of such information. Medicaid legal counsel and/or appropriate representatives of the attorney general's office shall be consulted, as deemed appropriate.

(b) Informal Inquiry:

1. If the Medicaid Director of Provider Audit, based upon such informal inquiry, determines that there is substantial evidence that the preparer has engaged in conduct specified in Rule 560-X-22-.28, he will give written notice to the preparer which will offer the preparer the opportunity to refute such information or

allegations. If the preparer fails to provide the Director of Provider Audit with information which results in a determination by the director that the evidence of misconduct is insufficient to justify suspension, the director will, at the preparer's request, have a hearing arranged and will have the preparer notified that such an administrative hearing will be held with regard to the alleged misconduct.

2. Should the preparer fail to deny or provide documentation or information to refute the allegations made against him within thirty (30) days after the date of the mailing of the initial letter to the preparer, such allegations will be deemed to be admitted, and the preparer will have waived hisright of hearing. The Director of Provider Audit will then notify the preparer of his suspension under this rule.

3. The above-described hearing will be set for a time no earlier than thirty (30) days after the date of the mailing of the initial letter to the preparer.

(c) Procedures Related to Informal Inquiry:

1. Notice. The initial notice from the Director of Provider Audit to the preparer will describe with sufficient specificity the allegations being made against him to allow him to respond to those allegations in a specific manner.

2. The Notice of Hearing. The notice of hearing to the preparer will repeat the allegations which constitute the basis for the proceedings and state the date, time, and place of the hearing. The hearing, as noted in Rule 560-X-22-.29(3)(b)1. above will be arranged only at the request of the preparer. Such notice shall be considered sufficient if it fairly informs the preparer of the allegations against him so that he is able to prepare his defense. Such notice may be mailed to the preparer by first class or certified mail, addressed to him at his last address known to the Director of Provider Audit. A response or correspondence from the preparer or his representative shall be mailed to Director of Provider Audit, Alabama Medicaid Agency, 501 Dexter Ave., Montgomery, Alabama 36104.

3. Answer. No written answer to the notice of hearing shall be required of the preparer.

4. Hearing. The hearing shall be conducted in accordance with Medicaid's regulations related to fair hearings. (Chapter 3 of the Alabama Medicaid Administrative Code.)

5. Failure to Appear. If the preparer fails to appear at the hearing after notice of the hearing has been sent to him, he shall have waived the right to a hearing and the Commissioner of Medicaid may make his or her determination without further proceedings.

6. Determination of Ineligibility. The determination of the ineligibility of a cost report preparer to prepare Medicaid cost reports will lie solely with the Commissioner of Medicaid. The commissioner will make such determination after giving due consideration to the written recommendation of the hearing officer, unless the preparer has waived his right to hearing, in which event there need be no recommendation by the hearing officer.

7. Notification of Ineligibility. If the determination of the commissioner is that the preparer shall no longer be eligible to prepare Medicaid cost reports, the preparer shall be notified in writing, and the preparer shall thereafter not be eligible to prepare such reports unless and until authorized by the Commissioner of Medicaid to do so. Such a preparer shall IN NO EVENT be eligible to prepare such cost reports during the two (2) year period immediately following his suspension. Any person who acts as a cost report preparer during his period of suspension shall not thereafter be eligible to act as a cost report preparer for a period of ten (10) years from the date of his original suspension. Any provider who knowingly allows a cost report to be prepared by a person who has been suspended under this section will be subject to having its provider agreement cancelled and will be subject to the applicable penalties of Rule 560-X-22-.28.

Author: Susan Mims
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§447.200 - .272, et seq.
History: Rule effective October 1, 1982. Amended effective September 9, 1988; October 1, 1990.

560-X-22-A **Appendix A.**

ALABAMA MEDICAID AGENCY
ADMINISTRATIVE CODE

CHAPTER 560-X-22

APPENDIX A
FORMS

1. Patient Count and Analysis Sheet

2. Mileage Log

3. Final Audit Computation

4. Composite Estimated Useful Lives of Depreciable Hospital Assets

Author:
Statutory Authority:
History: