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CHAPTER FORTY-TWO
ICF/IID REIMBURSEMENT

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Chapter 42 ICF/IID Reimbursement

Rule No. 560-X-42-.01 ICF/IID Reimbursement – Preface

This Regulation states the Medicaid policy regarding ICF/IID reimbursement and establishes the accepted procedures whereby reimbursement is made to these providers. Because of the length and complexity of this Chapter, it has been divided into sections to facilitate its utilization.

Author: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit

Statutory Authority: Code of Alabama, 41-22-2.

History: Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Amended: Filed May 12, 2017; effective June 26, 2017.

Rule No. 560-X-42-.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 ICF/IID care. This Chapter is applicable to those providers classified as ICF/IID.

(2) The Alabama Medicaid Program is administered by Medicaid under the direction of the Governor's Office. Reimbursement principles for ICF/IID providers 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 ICF/IIDs. These principles are not intended to be all inclusive, and additions, deletions, and changes to them will be made by Medicaid, 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 levels of care?
- (d) Is the cost related to resident care and necessary to the operations of an ICF/IID facility?

(4) It is recognized that there are many factors involved in operating an ICF/IID facility. The size of the home, the levels of care offered, 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.

(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. An ICF/IID administrator is expected to conduct his 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 ICF/IID 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 on-site 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 non-extravagant, 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 Program Integrity Division, 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: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.250-.255.

History: Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Amended: Filed May 12, 2017; effective June 26, 2017.

Rule No. 560-X-42-.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) Cash Basis of Accounting - Revenues and expenditures are recognized when cash is received and disbursed.

(3) Adjusted Reported Costs - The net reported costs from Schedule B, Column 3, of the cost report adjusted, as required, for unallowable costs, and cost recovery items.

(4) Medicaid - The Alabama Medicaid Agency.

(5) 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 ICF/IID facility.

(6) Allowable Costs - The costs of a provider of ICF/IID 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.

(7) Approved Bed Rate - The Medicaid rate paid to facilities for approved beds. (See Section 4 for computation.)

(8) Chapter - This Chapter of the Alabama Medicaid Agency Administrative Code.

(9) Class - Grouping formed according to type of facility. Medicaid classes to which this Chapter applies are: (1) Institutionally based, larger than 15 beds, (2) Institutionally based with at least four (4) but no more than fifteen (15) beds.

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

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

(12) 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.

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

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

(15) HIM-15 - The (publication) 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 42 are for the "Retrospective" Reasonable Cost Reimbursement Principles and not those of the 10-1-83 Prospective Medicare System.

(16) 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 resident who is not in the facility. Hold bed days do not include therapeutic leave covered by Medicaid.

(17) Home Office Costs - See Rule No. 560-X-42-.17 for in-depth discussion and treatment of home office costs.

(18) 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.

(19) 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 resident 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 resident care or safety.

(20) 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.

(21) Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) - That type of facility which fully meets all requirements for licensure under State law to provide on a regular basis, health related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities. The primary purpose of such institutions is to provide health and/or rehabilitative services for individuals with intellectual disabilities.

(22) Medicaid Occupancy - The percent of the total residents in an ICF/IID facility who have been certified eligible for Medicaid benefits.

(23) Medicaid Per Diem Rate - The amount paid by Medicaid for ICF/IID services provided to Medicaid residents for a one-day period.

(24) 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 ICF/IID services.

(25) 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 non-profit basis.

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

(27) 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.

(28) Related - The issue of whether the provider and another party are "related" will be determined under the HIM-15 rules defining "related parties."

(29) 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.

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

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

(32) 90th Percentile - The cost ceilings applied to the cost per resident day for Medicaid reimbursement is derived as follows:

(a) The ICF/IIDs are divided into their respective classes and are listed in ascending order based on their respective cost per resident day.

(b) The number of homes in each class is multiplied by 90% to determine the position of the ICF/IID facility that represents the 90th percentile. Thus, 90% of the homes in each class will have costs per resident that are equal to or less than that of the 90th percentile home. Likewise, the remaining homes will have costs per resident day in excess of the costs of the 90th percentile home.

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

(34) 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.

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

(36) Use Allowance - In lieu of depreciation, state owned and operated facilities may claim a use allowance. The annual use allowance for building and improvements shall be two

percent of acquisition cost. The annual use allowance for major movable equipment shall be six and two-thirds percent of acquisition cost.

(37) Unapproved Bed Rate - The Medicaid rate paid to ICF/IID facilities for unapproved beds (See Rule No. 560-X-42-.04 for computation.)

(38) Net Lease - A lease in which the tenant pays all or a substantial part of the cost of maintaining and operating the facility; (e.g., maintenance costs, insurance, and real estate taxes).

Author: Sandra Johnson, Director, Provider Audit

Statutory Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250 - .255, et seq.

History: Rule effective October 13, 1988. Effective date of this amendment September 13, 1989. Effective date of this amendment July 13, 1993. **Amended:** Filed May 12, 2017 effective June 26, 2017. **Amended:** Filed September 11, 2018; effective October 26, 2018. **Amended:** Filed: January 19, 2024; effective March 16, 2024.

Rule No. 560-X-42-.04 Medicaid Per Diem Rate Computation Methodology

- (1) All ICF/IID providers will be grouped into two (2) functional categories:
 - (a) ICF/IIDs larger than 15 beds.
 - (b) ICF/IIDs (15 beds or less).

(2) Within each grouping, 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 new per diem rates. The following methodology will be used for determining the per diem rates for approved beds.

(a) Net reported costs (Schedule B, Column 5 of the cost report) shall be adjusted for cost recovery items, unallowable cost and excess administrative costs.

(b) Costs as adjusted in (a) above (less any property cost) shall be separated into Salaries and other cost. The Other cost will be multiplied by the Medicaid inflation index to calculate a budgeted increase in other expense. To determine a projected increase in salaries, the amount or % increase specified by the provider shall be used.

(c) Budgeted increases/decreases (rent, depreciation, interest, major repairs) shall be calculated using as a basis data supplied by the provider.

(d) In lieu of depreciation, a use allowance shall be determined for buildings and improvements for State owned and operated facilities.

(e) The allowable equity capital will be multiplied by the percentage rate of return specified in Rule No. 560-X-42-.13 and the product will be the allowance for Return on Equity Capital. (This allowance applies to proprietary providers only.)

(f) The sum of the amounts as determined in (a) - (e) above shall be divided by total resident days as reported by the provider. The resulting average cost per day will be arrayed within each of the two functional groupings of facilities. The number of facilities in each grouping will be multiplied by 90% to determine the position of the facility that represents the 90th percentile. If the 90th percentile does not fall on a whole number, the Agency will round up or down to the nearest

whole number. If the number falls on a .0 to .49, we will round down. If the number falls on .50 or higher, we will round up. Counting from the bottom of the array (upward) that facility's cost in each grouping will be the ceiling reimbursement rate for all costs of the homes within that functional class.

Example:

1. Net Reported Costs (Schedule B, Column 5)
2. Deduct: Cost recovery items, unallowable cost, excess administrative compensation.
3. a. Separate Cost (less property cost) into salary and other cost.
b. Calculate the budgeted increase for salaries, add to salaries.
c. Multiply other cost by the Medicaid inflation index, add to other cost.
d. Add: Any budgeted increases/decreases (Rent, depreciation, interest, major repairs, add back property cost (if applicable) that was deducted in (a) above.
e. In lieu of depreciation, a use allowance for buildings and improvements shall be determined for State owned and operated facilities and added to cost as adjusted in (a) - (d) above.
f. Add allowance for return on equity (if applicable).
g. Total items (b) - (f) above. Divide this sum by total resident days as reported by the provider.
h. Determination of 90th percentile ceiling rate based on array of amounts in Item g for all providers within the grouping.

(3) Computation of a per diem rate for unapproved beds will follow the methodology as set out in sections 1 - 2 above, except that no return on equity capital will be allowed with respect to such unapproved beds. Also, there will be no depreciation, use allowance, interest, taxes or other such costs allocable to unapproved beds.

(4) Ceilings Not Subject to Adjustments. Once the percentile ceilings have been established for a fiscal year, they will be final and not normally subject to revision or adjustment during that year. Since the ceiling rates are based on information provided in the cost reports, it is to the benefit of each provider to insure that the provider's 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.

(5) 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.

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

(7) Dollar values are rounded.

Author: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit

Statutory Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250- .255.

History: Rule effective October 13, 1988 and amended December 12, 1988. Emergency rule effective July 1, 1989, and amended September 13, 1989 and July 13, 1993; and March 15, 1994. This amendment is effective March 14, 1996. **Amended:** Filed May 12, 2017; effective June 26, 2017.

Rule No. 560-X-42-.05 Medicaid Inflation Index

(1) The Medicaid Inflation Index will be used in lieu of budgeting to adjust certain actual allowable costs from the reporting period for the purpose of computing the prospective per diem rate payable 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 September 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 any later release of revised or additional information relevant to the determination of the index.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R., Section 447.250-.255. Rule effective October 13, 1988.

Rule No. 560-X-42-.06 Resident Days

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

(a) Care is rendered to a resident in the facility. This results when a resident 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 resident days resulting from care rendered to residents in the facility, using the midnight census method:

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

(b) When pre-admission payments are received to insure a bed is kept open for a particular resident. The rationale for including these payments lies in the fact that this bed is not available for occupancy by another resident. Since the facility is receiving payment for a bed which is, in effect, unavailable to any other resident, it should be included in resident day totals.

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

(d) Medicaid payments to ICF/IIDs for therapeutic visits will be limited to 14 days per calendar month, not to exceed 14 consecutive days at one time.

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

(a) Midnight census by resident 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 6A at the end of this Chapter is the recommended analysis sheet, however, providers may utilize any form of their own design which provides the same information.)

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

(a) Resident name

(b) Dates of pre-admission days charged

(c) Dates of preadmission days written off as uncollectable

(d) Reason for uncollectability

Author: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 447.250-.255 et seq.

History: Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Amended: Filed May 12, 2017; effective June 26, 2017.

Rule No. 560-X-42-.07 Management and Administrative Costs

(1) Costs of a management or administrative nature, including but not limited to those costs outlined in Rule No. 560-X-42-.07(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 non-administrative cost centers. Administrative compensation is limited to 10% of net allowable other cost, plus use allowance (if applicable).

(2) Customarily, owner compensation results from a distribution of the profits. However, when the owner provides a necessary service to the facility, and 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 ICF/IID 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 resident care, except those specified in Rule No. 560-X-42-.19)
- (c) Outside Accounting and Auditing
 - 1. Routine Bookkeeping
 - 2. Preparation of cost reports
 - 3. Auditing and related statements
- (d) Data Processing
 - 1. Owned
 - 2. Rented
 - 3. Outside purchased service
- (e) Professional Development
- (f) Supplies
 - 1. General administration
 - 2. Medical records
- (g) Telephone Expense - Subject to limitations in Rule No. 560-X-42-.19(u).
- (h) License
 - 1. Business
 - 2. Administrator's

- (i) Insurance
 - 1. Professional Malpractice (limited to provisions in HIM-15, 2163.3)
- (j) 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. Workmans Compensation Insurance (Non-State owned and operated facilities)
- (k) Advertising
 - 1. Telephone, local (not in excess of 5 square inches in yellow pages)
 - 2. Employment ads
 - 3. Public Relations ads (not in excess of \$100.00 per fiscal year).
- (l) Postage
- (m) Management Home Office Cost (chain operation)
 - 1. Management and administrative salaries and benefits.
 - 2. All building costs, including but not limited to:
 - (i) Insurance
 - (ii) Rent
 - (iii) Lease
 - (iv) Utilities
 - (v) Depreciation
 - (vi) Interest
- (n) Interest Expense on working capital loans, subject to limitations contained in Rules No. 560-X-42-.08 and 560-X-42-.19(3)(q).
- (o) Management fees not exceeding the cost of the provider of the services and not excluded under Rule No. 560-X-42-.19(3).

Author: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 447.250-.255.

History: Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Amended: Filed May 12, 2017; effective June 26, 2017.

Rule No. 560-X-42-.08 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 resident care. Loans which result in excess funds or which are not related to resident care are not considered to be necessary. In order to be considered reasonable, the interest 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 (Medicare Provider Reimbursement Manual) 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. However, the principal amount of such loans will be included in equity capital for the purpose of computing the return on equity payable to proprietary providers. This will be done in computing a

proprietary provider's return on equity, by eliminating the liability from the deduction from assets, thereby increasing the equity.

(2) Bond discounts or premiums 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 deducted from interest expense in the case of premiums.

(3) (a) Interest incurred during the period of construction on funds borrowed to construct 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 is put into use for resident 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.

(b) If a debt which was incurred to finance the construction, expansion, renovation or acquisition of an ICF/IID facility is refinanced, allowable interest on the refinanced portion of the original loan will be limited to the interest which would have been allowed under the original financing arrangement, and any additional interest on the refinanced portion will be an unallowable cost.

(4) If the provider incurs a prepayment penalty on the early extinguishment of an interest bearing debt, the amount of such interest penalty shall be allowable and treated as interest expense using the following guidelines:

(a) If accumulated interest plus penalty is less than the amount of interest that would have been incurred had the debt not been paid off, then all the interest and penalty can be claimed.

(b) If the interest and penalty exceed the amount of interest that would have been claimed had the debt not been paid off, then only the amount that would have been claimed during a reporting year can be included in the cost report. The excess penalty will be carried on the balance sheet as an asset and written off in subsequent years in a manner such that annual interest claimed does not exceed what the actual expense would have been.

(5) The payment of a lease payment to a Medical Clinic Board under a lease agreement containing a purchase option at a price below the fair market value is generally not allowable as a true lease payment, therefore the portion of the "lease payments" equal to the interest payments in the underlying bonds is subject to the limitations on reimbursement of interest expenses normally allowable as an interest expense.

(6) Interest must be reported on the cost report in two distinct areas: working capital interest, in the administrative cost center, and other interest reported in the property cost center.

(a) Working capital interest is limited to short term loans taken out to meet immediate needs of daily operations. If no evidence of repayment of these loans is apparent and a note is merely renewed or continued throughout the year, Medicaid will not consider these notes to be bona fide working capital loans, and interest expense will not be reimbursable. If these short term notes are repaid or a genuine effort has been made to repay them, interest expense will be limited to 90 days interest on two months of the provider's average allowable cost adjusted for depreciation and/or rent expense. The interest rate used for this computation will be the average rate charged by the lender during the year.

(b) Other interest includes mortgage interest and interest on loans to purchase equipment. The provider is required to have on file records to support the date, amount, and purpose of each loan. If the loans are of the installment type, an amortization schedule should also be available for inspection.

(7) 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 a loan agreement, under generally accepted accounting principles or created by imputing interest is not reimbursable. 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 an interest cost for purposes of computing the provider's allowable Medicaid reimbursement.

(8) If financing is obtained to purchase a facility, only the portion of the loan which pertains to the allowable purchase price, as defined by Medicaid, will be allowable. If this financing is a combination of assumed debt and other debt, the priority of allowability is as follows:

- (a) Assumed debt at the stated rate
- (b) Additional debt at the stated rate
- (c) Other debt

(9) If loans are made to related parties during the reporting period and working capital loans are created 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.

Author: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit

Statutory Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255.

History: Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Amended: Filed May 12, 2017; effective June 26, 2017.

Rule No. 560-X-42-.09 Laundry Expense

(1) Allowable costs will be limited to the laundry costs which are ordinary and necessary to the operation of an ICF/IID facility and will not include costs associated with the personal laundry of residents (if the facility charges for resident personal laundry).

- (2) Examples of such costs include, but are not limited to, the following:
- (a) Laundry salaries and employee benefits attributable to laundry personnel
 - (b) Supplies and materials used in providing laundry services
 - (c) Depreciation on equipment used in providing laundry services
 - (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 No. 560-X-42-.10, "Travel Expense".

(4) If the facility charges for resident personal laundry, the total cost of handling the personal laundry 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) If a facility elects not to charge sponsors or residents a personal laundry charge, Medicaid will not deduct a percentage of total laundry costs from the facility's rate computation.

Author: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit

Statutory Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R., Section 447.250-.255

History: Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Amended: Filed May 12, 2017; effective June 26, 2017.

Rule No. 560-X-42-.10 Travel Expense

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

(a) Automobile (This section (a) does not apply to State owned and operated facilities). The reasonable costs of automobile travel necessary for the maintenance of resident care shall be considered for purposes of reimbursement to facilities owned and operated by the State.

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 10A and 10B found at the end of this Chapter.)

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 ICF/IID facility is not allowable mileage for reimbursement purposes. (See Schedule 10A at the end of this 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. These rates will be applied on a per provider basis regardless of the number or type of vehicles used. (See Schedule 13-B at end of chapter.)

In addition to the mileage rate listed above, up to \$1,000.00 in actual operating costs (i.e., gas, oil, upkeep) per vehicle may be reimbursable. Medicaid will also allow depreciation of the cost of a new vehicle. Depreciation must be on the Straight line method for five years. There will be no additional reimbursement in those instances in which the facility auto is used for commuting purposes of the administrator or non-resident care related activities. To qualify for this additional allowance, the facility must own a vehicle, the vehicle must be used only for purposes of resident 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 \$1,000.00 will be recognized for any other automotive-related cost. Those additional costs which will not be recognized include, but not limited to:

- (i) Insurance
- (ii) Interest on automotive loans
- (iii) Lease/rental expense
- (iv) Taxes and tags
- (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.

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 air travel had been utilized and the costs normally incident to such air travel (meals, lodging, etc.).

4. No travel expenses of a non-business 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 \$10.00).

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

6. Costs incurred in travel outside the United States will not be reimbursed.

Author: Robin Arrington, Associate Director, LTC Provider/Recipients Services Unit
Statutory Authority: State Plan; Title XIX, Social Security Act; 42C.F.R., Section 447.250-.255.
History: Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.
Amended: Filed May 12, 2017; effective June 26, 2017.

Rule No. 560-X-42-.11 Property Costs

This rule does not apply to State owned and operated facilities who are paid a use allowance in lieu of depreciation for buildings and improvements. The annual use allowance for buildings and improvements shall be two percent of acquisition cost. Major movable equipment for State owned and operated facilities will be depreciated as in paragraph (10) of this rule.

(1) **Medicaid Approval.** The construction, sale or lease of any ICF/IID facility must be approved by Medicaid for purposes of Medicaid reimbursement. Medicaid may, at its option, elect not to approve any new construction, sale or lease of a facility entered into without its prior approval; in which case, Medicaid will not reimburse any property costs. Capital expenditures must be approved under applicable Certificate of Need regulations by appropriate state and/or federal agencies. When construction is accomplished without such approval, Medicaid will be able to pay only operating costs; capital expenditures will not be an allowable cost in these cases, as further explained in Rule No. 560-X-42-.04(3).

(2) **New Construction.** Construction costs as defined in Rule No. 560-X-42-.11(9) will be reimbursed on actual cost up to a maximum of \$16,600.00 per bed. This limitation is intended to discourage construction of lavish facilities.

(3) **Land.** The maximum allowable cost assigned to land upon which a newly constructed facility is built, or upon which a purchased facility is located, shall use as a guideline an amount not to exceed 5% of the construction costs (with respect to a newly constructed facility) or of the allowable basis determined pursuant to Rule No. 560-X-42-.11(4) with respect to a purchased facility) absent a showing by the provider that the 5% is not a reasonable amount. Each such construction or purchase situation shall be subject to the "prudent buyer" concept with each case to be considered on its own merits.

(4) **Sale of Existing Facilities.** Effective for sales closed on or after October 1, 1988, the allowable basis to the purchaser of a facility participating in the Medicaid program of those assets which would be includable as construction costs pursuant to Rule No. 560-X-42-.11(9) if the facility were being constructed rather than purchased, shall be the lower of:

(a) The actual sales price negotiated for the purchase of the facility. For purposes of this Rule, including but not limited to this section (a) and Section (7) (a) of this Rule, sales price shall mean the total price agreed upon by the seller and purchaser as evidenced by a signed copy of a final sales agreement. The stated sales price agreed to by the seller and the buyer shall not be reduced by any discount involved with issuance, by the purchaser of notes, mortgages, bonds, or securities, and the acceptance of such debt instruments as part of the agreed upon purchase price by the seller; or

(b) The current replacement cost of the facility [based upon the current Alabama Medicaid ceiling on Construction Costs of new facilities under Rule No. 560-X-42-.11(2) reduced as follows:

Age of Facility	Write Down
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1 - 10 yrs.	2.5% per year for each year of age up to 10 years
11 - 15 yrs.	25% plus 2.0% per year over 10 years
16 - 25 yrs.	35% plus 1.5% per year over 15 years
26 or older	50% plus 1.0% per year over 25 years

For purposes of this subsection (b), fractional years shall not be counted. Also, the maximum allowable basis of a facility, portions of which have been constructed at different times, will be calculated by considering separately each area of the building constructed at different times.

Example: Valuation of a 100 bed facility held 15 years

100 beds x \$16,600 = \$ 1,660,000
 Less: Depreciation

$[(\$1,660,000 \times 35\% (25\%)+(2\% \times 5)=35\%]$ (581,000)
 Maximum allowable depreciable basis \$ 1,079,000
 Land (limited to 5% of depreciable basis) 83,000
 (prior to write down, if applicable)
 Total Allowable Basis \$ 1,162,000

or;

(c) A purchase price which would represent an increase over the sales price paid by the seller of one-half of the percentage increase, from the date of acquisition by the seller to the date of sale by seller, in the Dodge Construction Systems Costs for Nursing Homes; or

(d) A purchase price which would represent an increase over the sales price paid by the seller of one-half of the percentage increase, from the date of acquisition by the seller to the date of sale by seller, in the Consumer Price Index for all Urban Consumers (United States city average).

(5) Seven Year Rule. No increase in property costs resulting from a change in ownership will be allowed for reimbursement purposes for a period of seven (7) years after the last change in ownership that resulted in a revaluation of depreciable basis or after the original construction of the facility. If a change occurs, reimbursement to the new owner will be under the same terms as under Rule No. 560-X-42-.11(11) related to non bona fide sales. Medicaid will consider granting exceptions to this seven (7) year rule, but only in cases of extreme hardship, such as death of the owner. Requests for such exceptions should be submitted in writing to the Commissioner of the Alabama Medicaid Agency and should be fully documented.

(6) Leases. The maximum lease payment which will be considered an allowable property cost will be the lower of (a) or (b), as follows:

(a) The actual lease payments which lessee is obligated to pay to the owner; or

(b) For net leases, 12% of the replacement cost of the facility [based on the current Medicaid ceiling on construction costs of new facilities under Rule No. 560-X-42-.11(2) adjusted as provided under Rule No. 560-X-42-.11(4)]. In those cases in which the depreciable assets have been stepped-up within the immediately preceding seven years, the 12% shall be applied to the net depreciated allowed book value at the date of the lease agreement.

(c) Leases submitted to the Agency for approval must be specific as to the responsibility for payment of fire and casualty insurance and property taxes. The maximum allowable lease payment calculated in (b) above includes an allowance for taxes and insurance.

(d) Sale/Leaseback Transactions. Reimbursement of rental or lease payments for these type transactions will be limited to the lower of: 1. the costs (depreciation, interest) of ownership which the facility would have been reimbursed had it retained legal title to the assets, or 2. The allowable Medicaid lease payment.

(7) Depreciation Recapture.

(a) Prior to Agency approval of the sale of a facility which has previously participated in the Medicaid program, all depreciation previously allowed and reimbursed through the per diem rate attributable to periods subsequent to the later of October 1, 1980, or the last recapture date will be recaptured. If the facility was sold at a price in excess of the sellers' cost of the property as reduced by accumulated depreciation, as computed under Medicaid depreciation guidelines, the recapture amount will be the lesser of the sellers' actual gain on the sale or the amount of the depreciation previously reimbursed through the per diem rate. Any gain based on the stated sales price agreed to by the seller and the buyer shall not be reduced by any discount involved with issuance by the purchaser of notes, mortgages, bonds, or securities, and the acceptance of such debt instruments as part of the agreed upon purchase price by the seller.

(b) Recapture of depreciation is not applicable in those instances where a stepped-up basis is not allowed, whether refused or is unallowable by the seven (7) year rule, or any other provisions of the regulations. Any subsequent sale, which results in a purchaser assuming a stepped-up basis, shall be subject to depreciation recapture from the later of October 1, 1980, or the last recapture date. The amount of recapture otherwise due to Medicaid from the seller of a facility which has been used in the Medicaid program will be ratably reduced commencing after that seller (regardless of that seller's method of acquisition) has owned the facility for 7 full years, at the rate of 1.04167% per month (being an annual rate of 12.5%). This reduction will result in no recapture being due once an owner has owned a facility for 15 full years. Each subsequent sale or other transfer of ownership is subject to a fifteen year holding period before the amount subject to recapture is reduced by 100%.

(c) If the seller's allowable costs during the seller's participation in the Medicaid program have in any year(s) exceeded the overall ceiling, the amount of depreciation subject to recapture will be determined as follows:

1. For any such fiscal year between October 1, 1980, and the date of sale, the amount of depreciation subject to recapture for each such year will be determined as follows:

(i) Reimbursement ceiling divided by average otherwise allowable cost per day (as shown on the rate computation schedule) = Reimbursement percentage.

(ii) Reimbursement percentage x depreciation x Medicaid occupancy = Amount of Recapture.

(iii) For partial fiscal years, the computation will be prorated based upon the number of full calendar months included in the partial year.

(d) Recapture will take the form of a lump sum repayment by the seller to Medicaid of the amount of depreciation computed under the depreciation recapture provisions as set out herein above. However, when Medicaid is requested to approve the sale of a facility wherein no arrangements are made for such a depreciation recapture payment by the seller, Medicaid may, notwithstanding any other provision of this section, withhold all reimbursement otherwise due to

the purchaser until such recapture repayment is fully recaptured from reimbursement otherwise payable to the purchaser.

(e) As to periods subsequent to October 1, 1980, during which a facility is leased to a Medicaid provider, and therefore, no depreciation is claimed as such for purposes of Medicaid reimbursement, the depreciation allowance which would have been reimbursable to the owner of the facility during the term of the lease if the owner had also been the provider will be computed. The amount so computed will be treated as "imputed depreciation" and will be subject to recapture from the seller as though such depreciation had been actually claimed and allowed for Medicaid reimbursement during the lease period. Medicaid will not approve the sale of a facility which has been leased until it is provided with adequate records (such as, but not limited to, federal income tax returns) from which it can compute the amount of "imputed depreciation."

(8) Facilities Financed by Bond Issues. Medicaid will treat the lease of a facility which has been financed by a Medical Clinical Board bond issue, pursuant to which the "lessee" has an option to purchase at less than market value, as a lease purchase agreement for reimbursement purposes. In these instances, the lessee's allowable property costs will be limited to the amount which would be allowable if the lessee had legal title to the facility's assets (the owner's allowable property costs) such as straight line depreciation, insurance, property taxes, interest, and an equity return on the investment in property, plant and equipment related to patient care, net of depreciation, and loans. The return on equity capital is subject to the provisions in Rule No. 560-X-42-.13.

(9) Definition of Construction Costs. "Construction Costs" include the cost of:

(a) Buildings. Buildings include, in a restrictive sense, the basic structure or shell and additions thereto. The remainder is identified as building equipment.

(b) Building Equipment. Building equipment includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating systems, air conditioning systems, etc. The general characteristics of this equipment are that it normally: (1) is affixed to the building and not subject to transfer; and (2) has a relatively long useful life, but the useful life is shorter than the useful life of the building to which affixed.

(c) Major Movable Equipment. Major movable equipment includes such items as beds, wheelchairs, desks, etc. The general characteristics of this equipment are that it: (1) has a relatively fixed location in the building; (2) is capable of being moved, as distinguished from building equipment; (3) has a unit cost sufficient to justify ledger control; and (4) has sufficient size and identity to make control feasible by means of identification tags.

(d) Land (Non-depreciable). Land (non-depreciable) is excluded from Construction Costs for purposes of the limitations on Construction Costs contained in Rule No. 560-X-42-.11(2). However, allowable land costs are subject to the limitation contained in Rule No. 560-X-42-.11(3).

(e) Land Improvements (Depreciable). Depreciable land improvements include paving, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc., if replacement is the responsibility of the provider.

(f) Capitalized Costs. Construction period interest and other expenses which are normally capitalized as part of the cost of the acquired property under generally accepted accounting principles.

(g) Acquisition costs such as feasibility studies, accounting fees, legal fees, etc., are not reimbursable costs for sales occurring on or after October 1, 1988.

(10) General Principles Relating to Property Costs. Property Costs include, but are not limited to, depreciation, interest, lease and rental payments, insurance on buildings and contents, and property taxes. In addition to the limitations contained in this Rule No. 560-X-42-.11, all property costs will be subject to the "prudent buyer" concept with each case to be considered on its own merits. Also, depreciation, interest, rent, insurance, and taxes associated with space and equipment used for non-covered services or activities must be eliminated from allowable property costs. Treatment of costs associated with the operation of a laundry is dealt with in detail in Rule No. 560-X-42-.09.

(a) Depreciation

1. In order to be allowable as a property cost, depreciation must be: (a) identifiable and recorded in the provider's accounting records; (b) based on the allowable historical cost of the asset; and (c) prorated over the estimated useful life of the asset using the straight line method. The useful life guidelines published by the American Hospital Association must be followed in establishing the useful life of a new asset. (See Schedule 11A at the end of this chapter.) The Agency may allow lives different from these guidelines, if the provider requests consideration in writing. Medicaid may allow used assets to be depreciated over shorter estimated useful lives if prior approval of such shorter useful lives is requested in writing by the provider. If such prior approval is not obtained, used assets will be depreciated over the same useful lives as established for new assets. For those assets not appearing on Schedule 11A at the end of this chapter, Medicaid will establish the appropriate useful life on a case-by-case basis.

2. The costs of improvements, including major leasehold improvements such as building additions, will be depreciated over the useful life of the improvements, regardless of the remaining term of any lease agreement.

3. Any gain attributable to periods during which a provider has participated in the Medicaid program, resulting from the disposal of equipment will be used to offset depreciation expenses for the year in which the gain is realized. Any loss attributable to periods during which a provider has participated in the Medicaid program and resulting from such a disposal will be added to allowable costs for the year during which the loss is realized. In determining the gain or loss, such gains or losses will be treated as having accrued ratably over the entire period during which the provider has owned the asset. The allowable aggregate amount of such gains and losses will be limited to 10% of the provider's total allowable depreciation for the year during which such gain or losses are realized. Any amounts in excess of this 10% will be carried forward to subsequent years, with the same 10% limitation applying until the total gain or loss is absorbed into an allowable cost year. No gain or loss will be recognized for purposes of this section from a trade-in of a depreciable asset. Refer to Rule No. 560-X-42-.11(10) (a) 4, for an explanation of the basis to be utilized whenever an asset is traded in.

4. Trade-Ins. When an asset is acquired by trading in an asset that was depreciated under the program, the basis for purposes of depreciation of the new asset will be the sum of the undepreciated balance of the old asset and the cash paid or to be paid.

(b) Interest. Subject to the provisions of Section 10 of this Rule, necessary and reasonable interest incurred to finance the purchase or construction of a facility, to purchase equipment, and to finance the cost of major repairs and renovations, is an allowable property cost. Interest on the portion of a loan which exceeds the construction or purchase price approved by Medicaid for the financed asset will not be included in property costs, but will be subject to the other interest provisions of Rule No. 560-X-42-.08. If an asset is refinanced by a current owner at a higher rate of interest, allowable interest on the refinanced portion of the original loan will, unless the entire

interest expense meets the necessary and reasonableness tests of Rule No. 560-X-42-.08, be limited to the interest which would have been allowed under the original financing arrangement. The excess interest on the refinanced portion will be an unallowable cost.

(c) Leases and Rental Payments. All major lease and rental agreements must be in writing and must be approved by Medicaid for Medicaid reimbursement purposes prior to the signing by the provider. Medicaid will, in all cases, exclude from the provider's allowable costs all lease payments made or accrued prior to Medicaid approval of the lease agreement. Medicaid may, however, at its option, elect not to reimburse any lease payments under, or any other property costs incurred in connection with, any lease entered without its prior approval.

1. Facility Leases. Leases will be subject to the "prudent buyer" concept with each case to be considered on its own merits. Factors considered by Medicaid in its review will include, but not be limited to, the age of the facility, current costs versus proposed costs, length of lease, existing debt service, and fair return to lessor. No lease will be approved which contains a "percentage of the gross" or "escalator" clause. The fact that a lease is being renegotiated will not be grounds for increasing the amount of the lease payment. Medicaid reserves the right to require an independent appraisal of the leased facility at the expense of the provider by an appraiser selected by Medicaid. For Medicaid reimbursement purposes, allowable rental payments between related parties cannot exceed the lessor's allowable property costs. Subleases which include payment in excess of that being made by sub lessors will not be honored as to the additional payments. No increase in a lease payment will be recognized if an increase in lease payment or an increase in property costs due to the sale of the facility has occurred during the immediately preceding seven (7) year period. Medicaid will consider granting exceptions to the seven (7) year rule, but only in cases of extreme hardship, such as the death of the owner. Requests for exceptions should be submitted in writing to the Commissioner of Medicaid and should be fully documented.

2. Equipment Rental. Reasonable costs of such rental equipment as is normally and traditionally rented by health care institutions and which is rented from a non-related organization, are allowable provided the arrangement does not constitute a lease-purchase agreement. All items leased under a lease-purchase agreement must be capitalized and depreciated over the useful life of the asset.

(d) 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 and not from a limited purpose insurer [Ref. HIM-15, Section 2162(2)] will be considered as allowable costs.

(e) 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.

(f) 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.

(g) Minor Equipment is not subject to the provisions of this Section. Minor equipment must be expensed as of the date of purchase. Minor equipment includes such items as waste baskets, bed pans, catheters, silverware, mops, buckets, sheets, towels, etc. The general characteristics of this equipment are (1) no fixed location and subject to use by various departments of the provider's facility; (2) comparatively small in size and unit cost; (3) subject to inventory control; (4) fairly large quantity in use; and (5) a useful life of approximately three years or less.

(h) Capitalization Level. Any asset with a per unit cost of \$500 or more with an expected useful life of three years or more must be capitalized. Any group purchase of assets (i.e., 10 mattresses, 4 beds, etc.) with an aggregate cost of \$1,000 or more with an aggregate expected useful life of three years or more must be capitalized.

(11) Non Bona Fide and Related Party Sales.

(a) Non Bona Fide Sales. If a facility changes ownership and a purchaser cannot justify that the sale was bona fide, the seller's book value shall be used by the purchaser as the basis for the depreciation of the purchased assets. In such cases, the purchaser shall record the historical cost and accumulated depreciation of the seller recognizable under the program, and these shall be considered as incurred by the purchaser for program reimbursement purposes. No additional interest expense or return on equity resulting from such a non bona fide sale will be reimbursable.

(b) Related Party Sales. Any sale between a provider and a "related party" will not be deemed a bona fide sale. The purchaser's cost basis in depreciable assets and the remaining depreciable life of assets purchased will be the same as that of the seller. The portion of the purchase price reasonably allocated to assets which is in excess of the seller's book value shall be entered as a separate item on the books of the purchaser and eliminated from the computation of allowable interest expense, allowable depreciation and return on equity capital for the purposes of Medicaid reimbursement. The provisions of HIM-15 shall be applicable in determining whether a sale is between related parties.

(12) Rate Computation. The allowable property costs (as defined in this section) will be added to the allowable other costs and return on equity capital for determination of the 90th percentile.

(13) Transactions Involving Corporate Stock. The purchase of the stock of a corporate provider will generally not be considered as a purchase of the provider's assets; therefore, such a stock purchase will not result in a revaluation of the assets of the provider. However, such a revaluation will be permitted upon the statutory merger or consolidation of the corporation provider with another corporation under the same circumstances wherein such a revaluation would be permitted by 42 CFR Section 413.134(k). Additionally, 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 a statutory merger, consolidation, or liquidation shall be subject to the same prior approval and basis limitations as though an outright sale of the assets has been made.

(14) Changes in Ownership. In a transfer which constitutes a change of 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 or which become due Medicaid from the old provider.

(15) Bed Additions or Replacement Beds. It is anticipated that bed additions to existing facilities will cost less than new facilities since these additions generally do not require additional administrative, dietary, and plant operation areas. Bed Additions or replacement bed construction costs built at the same location as the core facility will be reimbursed on an actual cost basis using \$12,000 per bed as a reasonable guideline. This limitation is intended to discourage construction of

lavish facilities. Appropriate adjustments to this \$12,000 per bed cost limitation may be made based on the availability of service areas in the existing facility.

(16) Renovations. Renovations to the existing facility will be reported as a separate cost breakdown.

(17) In those instances wherein a facility that is being leased is sold, the purchaser of the facility must furnish the Agency with documentation of the seller's actual facility acquisition cost prior to Medicaid computation of an allowable depreciable basis.

Author: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.250- .255, et seq.

History: Rule effective October 13, 1988. Amended September 13, 1989, and July 13, 1993.

Effective date of this amendment is March 14, 1996. **Amended:** Filed May 12, 2017; effective June 26, 2017.

Rule No. 560-X-42-.12 New Facility or Change in Ownership

(1) A provider who constructs, leases, or purchases a facility may request reimbursement based on an operating budget, subject to the ceiling established under Rules Number 4 and 5 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 September 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 September 30 regular report, the due date shall be November 30; 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 October 1st, 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 October 1st, a retroactive adjustment will be made for the current fiscal year only.

(4) 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 sixty (60) 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.

(a) Terminating cost reports will be subject to audit and retroactive adjustment. Any adjustment will be paid or recouped by a lump sum payment.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R., Section 447.250-.255. Rule effective October 13, 1988.

Rule No. 560-X-42-.13 Return on Equity Capital

(1) An allowance for reasonable return on equity capital invested and used in providing patient care is allowable as an element of the reasonable cost of services rendered by a proprietary provider.

(2) Equity capital is the difference between the net assets and net liabilities of a provider, adjusted for any asset or liability not related to patient care and any other non-allowable item provided for elsewhere in this Chapter.

(3) The amount of Net Working Capital (current assets minus current liabilities) which is includable in the computation of return on equity capital shall not exceed 1/9th of the provider's allowable costs for the fiscal year in issue.

(4) Providers that are members of chain operations must also include in equity capital a proportionate share of the equity capital, whether negative or positive, of the home office and/or directly related organizations. Amounts due to and from members of a chain, the home office, or any related service organization must be eliminated in computing equity capital.

(5) Unless specifically stated otherwise in this Chapter or HIM-15, current assets and current liabilities will be determined in accordance with generally accepted accounting principles. Accounts must be maintained by the accrual method of accounting in compliance with Rule No. 560-X-42-.21. Accounts not maintained accordingly will result in equity capital not being included in the provider's rate computation until the required documentation of those accounts is provided Medicaid. Examples of assets and liabilities included in the determination of equity capital are as follows:

(a) Cost of fixed assets such as land, buildings and equipment, reduced by accumulated depreciation

(b) Net working Capital (all other assets minus all other liabilities except specific exclusions)

1. Assets

(i) Cash on hand in banks

(ii) Current accounts receivable will include only those accounts for which diligent, documented effort is being made to collect

(iii) Notes Receivable

(iv) Other Receivables

(v) Inventory

(vi) Deposits on Leases

(vii) Bond Discounts (net amortization)

(viii) Prepaid Expenses (except prepaid life and auto insurance premiums)

(ix) Other Assets

2. Liabilities

(i) Current Accounts Payable (payables over one year old may be adjusted as Medicaid deems necessary)

(ii) Notes Payable

(iii) Salaries and Fees Payable (must be paid within 75 days of the balance sheet date)

(iv) Payroll Taxes Payable

(v) Deferred Income (must be received within 75 days of the balance sheet date)

(vi) Ad Valorem Taxes Payable

(vii) Accrued Federal and State Income Taxes

(viii) Accrued Expenses

(ix) Bond Premiums (net of amortization)

(x) Other Debts

(6) Assets and liabilities not related to providing resident care are not includable in the provider's equity capital. Examples of excludable assets are as follows:

(a) Funded Depreciation Account. Where the provider establishes an account in which amounts representing payments received or amounts accrued for depreciation expense are deposited, the amounts deposited in this account and the earnings on the funded depreciation which remain in the fund are not includable in equity capital.

(b) Assets Held in Anticipation of Expansion. The costs attributable to land, buildings, or other assets held in anticipation of expansion are not includable in equity capital as long as they are not being used in the operation or maintenance of resident care activities. Liabilities related to these assets will also be excluded. Construction-in-process and liabilities related to such construction are not includable in equity capital.

(c) Cash Surrender Value of Life Insurance. Where a provider carries life insurance on officers, owners, or key employees with the provider designated as the beneficiary, the cash surrender value of such insurance is not included in equity capital.

(d) Prepaid Life Insurance. Prepaid premiums on life insurance carried by a provider on officers, owners, and key employees are not included in equity capital.

(e) Goodwill. The costs of acquiring or generating good will is not includable in the provider's equity capital.

(f) Prepaid Auto Insurance. That portion of a provider's general insurance premium that is prepaid and related to automobiles is not includable in equity.

(g) Restricted Funds.

(7) Accrued Federal and State Income Taxes will be treated as a liability in computing a provider's equity capital.

(8) The portion of debts representing bona fide loans from partners, stockholders, or a related organization which is outstanding during the entire cost reporting period and on which interest payments are not allowable as costs is considered to be invested capital of the provider. By not subtracting it from assets, the equity capital of the provider is increased.

(9) The rate of return on equity capital is a per annum percentage equal to the yearly average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund. These interest rates are available from the Social Security Administration on a monthly basis, and the average will be computed on a yearly basis for the twelve month period ending on the last day of the relevant cost reporting period.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.14 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 plans 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 the employer. 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) Medicaid will not recognize employee stock ownership plans or stock bonus plans that were not both in operation and approved prior to October 1, 1980.

(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.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.250-.255. Rule effective October 13, 1988.

Rule No. 560-X-42-.15 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) Under no circumstances will rent paid to a Related Party be includable in allowable costs. In such cases, lessor's costs, including an appropriate amount of equity capital, may be included in allowable costs provided that such costs do not exceed the fair market value of the leased assets.

(3) The provisions of HIM-15 shall be applicable in determining whether a Related Party relationship exists.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988.

Rule No. 560-X-42-.16 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 residents)
- (e) Medicare Part B - Income
- (f) Sale of meals
- (g) Vending machines
- (h) Meal income (from meals served to guests or employees).
- (i) Other expenses not appropriate in developing and maintaining adequate resident care facilities
- (j) Contributions/donations
- (k) Federal Revenue (Designated)

(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.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.17 Chain Operations

(1) A chain organization consists of a group of two or more ICF/IID 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 ICF/IID 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 services already provided in the ICF/IID 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 an ICF/IID facility owned or operated by a chain than would be paid for an individually operated ICF/IID. 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

- (i) Salaries and Benefits
- (ii) Supplies
- (iii) Materials
- (iv) Travel expense subject to limitations contained in Rule 560-X-42-.10

2. Central Purchasing

- (i) Salaries and Benefits
- (ii) Goods
- (iii) Supplies
- (iv) Materials
- (v) Travel expense subject to limitations contained in Rule 560-X-42-.10
- (vi) Building Costs
 - (I) Insurance
 - (II) Rent
 - (III) Lease
 - (IV) Utilities
 - (V) Depreciation
 - (VI) Interest

3. Laundry

- (i) Salaries and Benefits
- (ii) Supplies
- (iii) Materials
- (iv) Travel expense subject to limitations contained in Rule No. 560-X-42-.10
- (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 allocable should be allocated among the providers (and to any non-provider 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 total square 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, central purchasing, and laundry costs will be classified as Administrative and Management costs and will be subject to the limitations contained in Rule No. 560-X-42-.07. Allocation of these costs to a facility will be on the basis of resident days.

(6) Equity Capital

See Rule No. 560-X-42-.13 of this Code.

Author: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit

Statutory Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255.

History: Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Amended: Filed May 12, 2017; effective June 26, 2017.

Rule No. 560-X-42-.18 Cost Allocation

(1) Multiple use 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

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988.

Rule No. 560-X-42-.19 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 resident 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 resident care include necessary and proper costs involved in developing and maintaining the efficient operation of resident care facilities. Necessary and proper costs related to resident care are those which are usual and accepted expenses of similar providers.

(2) 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 ICF/IID Program. Examples of such costs include, but are not limited to:

- (a) Prescription Drugs (which can be billed by a state owned provider to the Pharmacy Program)
- (b) Dental Expense (except consultant fees)
- (c) Physicians' Fees other than the Medical Director
- (d) Laboratory Expense for Residents (which can be billed by a laboratory to the Alabama Medicaid Laboratory Program)
- (e) Ambulance Service

(3) Administrative Costs Items 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 resident care will not be reimbursed by the Alabama Medicaid Agency.

- (a) Management Fees
 - 1. Management firms, individuals and consultants which duplicate services already provided, or in a facility in which a full-time licensed administrator is employed.
- (b) Director's Fees
- (c) Compensation to owners and other personnel not performing necessary functions (See Rule No. 560-X-42-.07)
- (d) Salaries which are paid personnel performing overlapping or duplicate functions
- (e) Legal Fees and Expenses
 - 1. Retainers
 - 2. Relating to informal conferences and fair hearings
 - 3. Relating to issuance and sale of capital stock and other securities
 - 4. Relating to creation of corporations and partnerships
 - 5. Relating to business reorganization

- 6. Services for benefits of stockholders
- 7. Acquisition of ICF/IID facilities or other business enterprises
- 8. Relating to sale of ICF/IID 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 resident 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 ICF/IID facilities or other business enterprises
 - 9. Relating to sale of ICF/IID facilities and other enterprises
 - 10. In connection with participation in criminal actions resulting in guilt or equivalent action or plea
 - 11. Feasibility studies, however, such fees may be capitalized as a Construction Cost under Rule 560-X-42-.11.
 - 12. Other Accounting services not related to resident 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
 - 5. Non-resident care related organization
- (i) Insurance
 - 1. Life
 - 2. Personal property not used in resident care
 - 3. On real estate not used in providing resident 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 No. 560-X-42-.07 of this Chapter.
- (k) Chaplains/Spiritual Advisors
- (l) Bad debts and associated collection expenses
- (m) Employees relocation expenses
- (n) 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

(o) Certain Real Estate Expenses

1. Appraisals obtained in connection with the sale or lease of an ICF/IID facility (unless required by Medicaid)

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

(p) Interest Expense

1. Interest associated with real estate in excess of ICF/IID facility needs or real estate not related to resident 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 resident care

7. Interest on loans not associated with resident 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 No. 560-X-42-.08.

(q) Licenses

1. Consultants

2. Professional personnel

(r) Donations and Contributions

(s) Accreditation Surveys

(t) 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.

2. Long distance telephone calls of a personal nature

(u) 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 and incorporation fees.

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

(w) Medicaid administrative fee.

(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.

(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.

(5) Non-Covered 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-42-.09, radio, television, telephone, and vending machines).

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

1. Materials or goods
2. Supplies
3. Salaries and Employee Benefits
4. Depreciation, interest, rent, utilities, and insurance on space and equipment

(6) Beauty and Barber Services

(a) If the ICF/IID facility makes no charge to the resident 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 ICF/IID facility makes a charge to the resident 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 Non-Allowable 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 as condition to participation in the ICF program

(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 for individual residents
- (d) Off premise telephone service
- (e) Farm expense

- (f) Real estate costs associated with real estate ownership in excess of ICF/IID facility needs and not related to resident care
- (g) Sitter services or private duty nurses
- (h) Cost of meals served to guests and employees
- (i) Fund raising expenses
- (j) Other expenses not appropriate in developing and maintaining adequate resident care facilities
- (k) Any expenses for service or supplies not routinely available to all residents as needed
- (l) Payments to doctors, dentists, etc., for services provided individual residents

(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: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit

Statutory Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255.

History: Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Amended: Filed May 12, 2017; effective June 26, 2017.

Rule No. 560-X-42-.20 Cost Reports

(1) Extensions. Each provider is required to file a complete uniform cost report for each fiscal year ending September 30th. The complete uniform cost report must be received by Medicaid on or before November 30th. Should November 30th fall on a state holiday or weekend, the complete uniform cost report will be due the next 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 ICF/IID 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.

(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 the overpayment amount.

(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 complete 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

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 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 sixty (60) 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. [See Rule No. 560-X-42-.20(2).]

(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.

Author: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit

Statutory Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255.

History: Rule effective October 13, 1988. **Amended:** Filed May 12, 2017; effective June 26, 2017.

Rule No. 560-X-42-.21 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 revenue must 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) Residents Personal Funds Records
- (g) Resident Admission and Discharge records
- (h) Purchases Journal (For facilities larger than 100 beds)

(4) 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 be charged. 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: (items marked by * do not apply to State owned and operated facilities)

- (a) Accounts Receivable ledger sheets or cards which agree with the General Ledger control account (to include September 30 aging schedules).
- (b) Accounts Payable Ledger sheets or cards which agree with the General Ledger control accounts (to include September 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. (State owned and operated facilities will provide non consumable property inventory that shows use allowance).
- (h) Payroll Tax Returns*
- (i) Income Tax Returns*
- (j) Census Records (See Schedule 6A)
- (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 or on behalf of the provider which substantiate data in the cost reports must be made available to Medicaid auditors and investigators upon request. These records must be maintained for at least three years, plus the current year, following the date of submission of the relevant cost report.

(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) 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.

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

(11) 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. The provider will also be subject to termination and other sanctions under the Medicaid program.

(12) 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: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit

Statutory Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255.

History: Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Amended: Filed May 12, 2107; effective June 26, 2017.

Rule No. 560-X-42-.22 Resident Personal Fund Accounts

(1) Personal Fund Management. In accordance with Federal Regulations for Medicare and Medicaid Facilities, a Medical Assistance resident may manage his personal affairs unless a facility accepts the resident's delegation of this responsibility. A resident managing his personal affairs may voluntarily have a facility hold custody of his funds.

(2) Voluntary Resident Delegation of Responsibility to the Facility. There are at least three (3) specific categories of Medical Assistance residents 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 Resident Fund Account

(a) All resident funds for which the facility has accepted delegation or legal responsibility will be maintained in a separate General Resident 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 residents 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.

(4) Endorsements, Receipts, and Deposits

The facility shall present checks or other receipts for moneys to the resident for his personal endorsement prior to depositing them in the facility's General Resident Fund Account. If funds received by the facility do not require endorsement, the facility will insure that all such funds are properly posted in the individual Resident Subsidiary Ledger. Unless prior written authorization is

given by the resident 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 Resident Fund Account

(a) A facility may not use a Medicaid resident'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 resident for undelivered personal services such as manicures, haircuts, hair styling, laundry, and dry cleaning.

(c) The resident or his/her sponsor must have freedom of choice in determining the purpose for which the resident's personal funds will be spent.

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

(e) In case of death, all remaining funds shall be returned by check to the resident's estate.

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

(a) General Resident Fund Account

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

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

(b) Individual Resident Subsidiary Ledger

1. An Individual Resident Ledger, which may be a card or computer record, shall be maintained for each Medicaid resident 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 Medicaid resident'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 Savings Account of Total Resident Funds

1. The facility must deposit in a Federally insured savings account all funds in excess of \$50.00 per resident.

2. An account of the total amount of resident's funds deposited in a savings account is to be maintained by the facility.

3. The facility may not use interest earned on resident funds to meet the costs of maintaining the resident funds.

4. Interest earned must be appropriately apportioned to each member's account balance during the period involved.

(d) Petty Cash Fund Records

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

2. When the Petty Cash Fund is replenished, the amounts of the disbursements shall be posted to the Individual Resident Subsidiary Ledger.

(e) Inadequate Records when individual resident subsidiary ledgers or records do not reconcile with the Resident Personal Fund Bank Accounts and/or control account, the resident'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 resident 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.

(7) Reporting of Resident's Funds Quarterly Report to resident. In accordance with Federal regulations, at least once every three (3) months, the facility will give the resident, or the resident's legally responsible relative or legal guardian, a copy of the Individual Subsidiary Resident Ledger Card or computer printout listing all deposits, disbursements, and the current balance.

(8) Assurance of Financial Security. The facility must purchase a surety bond to assure the security of all personal funds of residents deposited with the facility.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.23 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 copy of the report of audit will be forwarded to the Reimbursement and Rate Analysis Section when the report of audit is mailed to the facility. After the thirty (30) day notification period is up and no request for an informal conference has been received, a new per diem rate will be calculated based on audit adjustments in the report of audit. The new per diem rate will be effective for billing purposes on the 1st day of the following month. A final audit computation sheet will be prepared. The audit settlement will be collected or paid in a lump sum amount. This lump sum amount for the months prior to the effective date of the rate change is computed by applying the adjustment per resident day to the total Medicaid days in the overpayment/underpayment period.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.24 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.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.25 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 No. 560-X-42-.25 of this Code 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, 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 No. 560-X-42-.25(.02) of this Code 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 No. 560-X-42-.25(.02) 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 resident care which has previously been disallowed.

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

(6) Rule No. 560-X-42-.25 shall NOT be interpreted as indicating that a provider's or his representative's 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 provider agreement, and, in addition, subsequent reimbursement otherwise due the provider shall be reduced by a \$1400.00 penalty.

(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.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.26 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 any Medicaid 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 Rule No. 560-X-42-.26 of this Section, such information shall be promptly reported to Medicaid's Chief Auditor who shall insure 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 Chief Auditor, based upon such informal inquiry, determines that there is substantial evidence that the preparer has engaged in conduct specified in Rule 560-X-42-.25, he/she 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 Chief Auditor with information which results in a determination by the Chief Auditor that the evidence of misconduct is insufficient to justify suspension, the Chief Auditor 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 his right of hearing. The Chief Auditor 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 and Hearing.

1. Notice. The initial notice from the Chief Auditor 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 No. 560-X-42-.26(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 Chief Auditor. A response or correspondence from the preparer or his representative shall be mailed to Chief Auditor, Alabama Medicaid Agency.

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 (Chapter 3 of the Alabama Medicaid Administrative Code) related to Fair Hearings.

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 be present. The hearing officer may proceed with the conduct of the hearing and make his/her recommendation to the Commissioner of Medicaid who may make his or her determination.

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.

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 No. 560-X-42-.25 of this Code.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.