Attachment H
UC Payment Protocol

OVERVIEW

This Uncompensated-Care (UC) Payment Protocol is submitted pursuant to the Special Terms and Conditions (STCs) of the Texas Healthcare Transformation and Quality Improvement Program, Section 1115 Waiver Demonstration No. 11-W-00278/6. This protocol establishes the rules and guidelines for the State to claim federal matching funds for UC payments.

STC 33 provides that payments from the UC pool will be used to defray the actual uncompensated cost of medical services provided to uninsured individuals as charity care (as defined below) by hospitals, clinics, or other provider types. Expenditures for UC payments must be claimed in accordance with CMS-approved claiming protocols for each provider type as described in this Attachment H.

STC 33 further provides that the UC Payment Protocol must include precise definitions of eligible uncompensated provider charity care costs. For all provider types, the following definition applies:

> *Charity care*: Healthcare services provided without expectation of reimbursement to uninsured individuals who meet the provider's charity-care policy. The charity care policy should adhere to the charity-care principles of the Healthcare Financial Management Association. In this protocol, the term charity care also includes full or partial discounts given to individuals who meet the provider's financial assistance policy. Charity care does not include bad debt, payment shortfall(s), insurance allowances, courtesy allowances, or discounts given to patients who do not meet the provider's charity care policy or financial assistance policy.

The term "payment shortfalls" refers to government program payment shortfalls, e.g. Medicaid payments to providers.

Insurance allowances refer to the negotiated rates between insurers and providers, e.g. BCBS paying 60% of a provider's charge list for a Medicaid patient's care. CMS would not recognize for purposes of the UC pool the remaining 40% of costs not reimbursed by an insurer, as it stems from an insurance allowance. The unmet amount left over after a discounted charge to a patient who meets the provider's financial assistance policy would be acceptable.

Additional provider-specific descriptions of eligible charity-care costs may be included in Parts 1 - 4 of this protocol.

STC 33 further provides that the protocol must:

- Identify the allowable source documents to support costs;
- Include detailed instructions regarding the calculation and documentation of eligible costs; and
- Include a timetable and reconciliation of payments against actual charity-care cost and documentation.

This Payment Protocol is organized to provide the required information by provider type as follows:

Part 1: Hospitals
Part 2: Physician Practice Groups
Part 3: Government Dental Providers
Part 4: Government Ambulance Providers

Part 5: Methodology for Ensuring Payments Are Based On Uncompensated Costs

STC 33 also requires that the protocol describe the methodology used by the state to determine UC payments to hospitals, clinics, and other providers are distributed based on uncompensated cost, without any relationship to the source of the non-federal share. This requirement is met in Part 5 of this protocol.

Attachment H
UC Payment Protocol

Part 1: Hospitals

Hospitals that submit the UC application described below and meet other qualification criteria are eligible to receive payments from the UC Pool to help defray the unreimbursed costs incurred by the hospitals for providing the following services to individuals as charity care:

- Inpatient hospital services;
- Outpatient hospital services;
- Physician and mid-level professional direct-patient-care services; and
- Pharmacy costs related to prescription drugs provided through the Texas Vendor Drug program.

Pursuant to STC 33, providers receiving both DSH and UC payments cannot receive total payments under the UC Pool (related to inpatient and outpatient hospital services provided to charity care individuals) and DSH payments that exceed the hospital's total eligible uncompensated costs. For purposes of this requirement, "total eligible uncompensated costs" means the hospital's DSH hospital-specific limit (HSL) plus the uncompensated costs of inpatient and outpatient services provided to uninsured charity-care patients not included in the HSL for the corresponding program year non-covered inpatient and outpatient services provided to charity-care patients. Therefore, before calculating interim UC payment amounts for a hospital in this group, HHSC will first calculate the DSH HSL and the amount of DSH payments the hospital is expected to receive for the program year. The hospital's UC payment associated with costs that are included in the DSH HSL calculation cannot exceed the remaining DSH HSL after the DSH payments have been calculated. Costs and payments attributable to physician and mid-level professional services, pharmacy, and clinic services are not included for purposes of calculating total eligible uncompensated costs in this context.

Additionally, for institutions of mental diseases (IMDs), expenditures for services to patients in an institution for mental diseases (IMD) who are under age 65, except inpatient psychiatric hospital services to individuals under age 21, while allowable for purposes of the DSH HSL calculation, are not allowable costs for reimbursement from the UC Pool. Therefore, for IMDs participating in both DSH and UC, the UC payment associated with costs in the DSH HSL cannot exceed the lesser of the IMD's cost for providing services to the age-restricted population and the remaining DSH HSL after the DSH payments have been calculated.

Instructions regarding the calculation and documentation of these eligible costs are included in the description below of the Texas Hospital Uncompensated Care Application (TXHUC).

The costs and other data included in the UC application should be representative of the fiscal period from October 1 through September 30 two years before the demonstration year for which payments are being calculated. The UC application should be submitted to the Texas Health and Human Services Commission (HHSC) by the deadline specified by HHSC. For hospitals, the source for these costs and other data will be the hospital's Medicare cost report that ends in the calendar year two years prior to the demonstration year for which UC payments are being determined, except that non-public hospitals required to make a mandatory payment (i.e., a provider tax or provider fee) to a local governmental entity may report on the UC application the amount of such payments that are proportionate to the hospital's charity care services, whether such payment is included in the cost report or not. The application provides instructions for determining the amount of such cost that may be claimed as charity care. It should be noted that when HHSC completes the reconciliation process described in this protocol, HHSC will utilize the hospital's actual data reported on the reconciliation surveys and best available cost reports to ensure that the hospital's payments did not exceed its eligible costs.

All costs and other data reported in the UC Application are subject to the Medicare regulations and

program instructions. The entity submitting the UC Application must maintain adequate supporting documentation for all information included in the UC Application in accordance with the Medicare program's data retention policies. The entity must submit the supporting documentation upon request from HHSC.

Texas Hospital Uncompensated Care Tool (TXHUC)

The TXHUC comprises a certification page, five primary schedules (a Summary Schedule and Schedules 1, 2, 3 & 4) and various other supporting schedules. Schedules 1, 2 and 3 determine the hospital's unreimbursed costs for services provided to patients related to physician and/or mid-level professional direct patient care costs, pharmacy costs, and allowable hospital costs for the UC programs. Schedule 4 identifies allowable hospital costs for DSH payments. The supporting schedules are the schedules hospitals are required to submit to HHSC when applying for the Medicaid DSH program and also to report allowable charity charges for UC payments. Each of these schedules along with instructions for the completion of the schedule is detailed below.

Certification

The certification page must be signed and dated by an officer or administrator of the provider. An officer is defined as a member of the provider's senior management such as the chief executive officer, chief financial officer, chief operating officer, etc. The certification must contain an original or acceptable electronic signature and not a copy. If the TXHUC is an initial submission, it should be so indicated in the appropriate box on the certification page.

Upon the termination of the 1115 Waiver, providers will be required to submit actual cost data in the prescribed format of the TXHUC for a minimum of two years for purposes of reconciling the UC Pool payments for the last two years of the Waiver with the provider's actual costs incurred for those fiscal periods

Summary Schedule

Column 1 - Summarizes the charity costs determined on Schedules 1, 2 & 3. These amounts will flow automatically from the respective schedules and no input is required.

Column 2 – The distribution of the Uncompensated Care Pool ("UC Pool") will be based on the charity costs incurred two years prior to the demonstration year. For example, distribution for the fiscal period 10/1/2019 - 9/30/2020 will be based on costs that are representative of the period from 10/1/2017 – 9/30/2018 as computed on Schedules 1, 2 & 3. If the provider knows these costs are not representative of their actual costs due to changes in their contractual arrangements or other operational or economic issues, the provider can enter adjustments to these costs in this column. The provider is required to maintain supporting documentation to support their adjustment amount and make this information available upon request from HHSC and/or CMS.

Column 3 – Represents the net charity costs after any adjustments and is determined by summing the amounts in Columns 1 & 2. The net cost amount will be utilized to determine the provider's distribution from the UC Pool.

Schedule 1
The schedule computes the costs related to direct patient care services provided by physicians and mid-level professionals to patients qualifying for charity care. To be included in the schedule, these costs must be recorded on the hospital's accounting records and reported on the hospital's Medicare cost report, Worksheet A, Columns 1 and/or 2.

Unless otherwise instructed, the source for these costs and other data will be the hospital's Medicare cost report for the period that ends in the calendar year two years prior to the demonstration year for which UC payments are being determined.

Column 1 - The direct patient care physician and/or mid-level professional costs are identified from the Medicare cost report. These professional costs are:

(1) Limited to allowable and auditable physician and/or mid-level professional compensations that has been incurred by the hospital;
(2) Physician's services to individual patients identified as professional component costs on Worksheet A-8-2, Column 4 of the cost report(s);
(3) Or, for contracted physicians and/or mid-level professionals only, Worksheet A-8, if the physician and/or mid-level professional compensation cost is not reported by the hospital on Worksheet A-8-2 because the physicians are contracted solely for direct patient care activities (i.e., no administrative, teaching, research, or any other provider component or non-patient care activities); and
(4) Removed from hospital costs on Worksheet A-8 / A-8-2

If the professional physicians' costs on Worksheet A-8-2, Column 4 include Medicare Part A costs (e.g. departmental administration, hospital committee activities, etc.) that were reported as professional component due to lack of a physicians' time study(s) to allocate the costs between professional and provider component and/or application of the Reasonable Compensation Equivalents (RCE) , these costs must be excluded from the physicians' costs related to direct patient care professional services and cannot be included for UC reimbursement purposes unless the following conditions are met:

(1) The costs must be allocated between direct patient care (Medicare Part B) and reimbursable Medicare Part A activities. The costs associated with Medicare Part A activities must be subjected to the Medicare RCEs.
(2) For a physician the hospital can elect to apply the RCE limit on an individual physician basis or in the aggregate.
(3) The hospital must allocate the physicians' costs based on the physicians' time study and apply the applicable RCE limits to the Medicare Part A non-teaching physicians' costs. The hospital must maintain auditable documentation of the determination of the allowable Part A non-teaching physician costs.
(4) The hospital is expected to obtain adequate and auditable time studies from each physician and time proxies from each mid-level professional employed by the hospital providing Medicare Part A services to the hospital for the proper application of the RCEs via the Medicare 2552 cost report. The physician and/or mid-level professional time study and time proxy forms to be used are located on the Texas Health and Human Services Commission website. Time studies should be completed for a two (2) week period once per quarter during the fiscal year. Ideally, the time study period will not be the same two weeks in any two given quarters. Medicare Part A physician and/or mid-level professional costs are not allowed to be included in the UC tool for cost reporting periods. In instances where a physician or mid-level professional is able to provide a contract that scopes out the specific direct patient

care being provided and that contains the same information provided by a time study or time proxy, that contract may be used for payment and reconciliation purposes. The time proxy must be signed by each midlevel professional employed by the hospital and the supervisor for cost reporting periods beginning on or after 10-1-2012.

Physician Part A costs cannot be included in Column 1. The physicians' costs should be reported in the cost center in which the expenses were reported on Worksheet A, Column 3 of the Medicare cost report.

Hospital costs for mid-level professional practitioner services that have been identified and removed from hospital costs on the Medicare cost report are to be included. Typically these costs comprise salaries and direct fringe benefits (payroll taxes, vacation and sick pay, health and life insurance, etc.), contract fees and professional liability insurance. The mid-level professional practitioner types to be included are:

(1) Certified Registered Nurse Anesthetists
(2) Nurse Practitioners
(3) Physician Assistants
(4) Dentists
(5) Certified Nurse Midwives
(6) Clinical Social Workers
(7) Clinical Psychologists
(8) Optometrists

To the extent these mid-level practitioners' professional compensation costs are not included in Worksheet A-8-2, Column 4, but are instead removed from hospital costs through an A-8 adjustment on the Medicare cost report, these costs may be recognized if the mid-level professional practitioners are Medicaid-qualified practitioners for whom the services are billable under Medicare separate from hospital services.

If the physician and/or mid-level practitioner costs are reported in a non-reimbursable cost center on the hospital's Medicare cost report, Worksheet A, these costs can be included in Column 1. The costs to be included would be the costs from Worksheet B Part I, the last column for the applicable line(s).

Hospitals may include physician and/or mid-level professional support staff compensation, data processing, and patient accounting costs as physician and/or mid-level professional-related costs to the extent that:

(1) These costs are removed from hospital inpatient and outpatient costs because they have been specifically identified as costs related to physician and/or mid-level professional services;
(2) They are directly identified on W/S A-8 as adjustments to hospital costs;
(3) They are otherwise allowable and auditable provider costs; and
(4) They are further adjusted for any non-patient-care activities such as research based on the physician and/or mid-level professional time studies.
(5) They are directly identified in a non-reimbursable cost center on the hospital's Medicare cost report, Worksheet A.
(6) For cost reporting periods beginning on or after 10-1-2013, physician and mid-level direct patient care costs incurred by the hospital that have been reported and removed from the hospital-based RHC cost center in the hospital's cost report through an adjustment in worksheets A-8 or A-8-2 (column 4) are allowable in

Schedule 1 of the application. Hospitals must provide adequate support documentation such as time studies for physicians and time proxies at a minimum for mid-level professionals to ensure only direct patient care is included in schedule 1. A copy of the contract between the hospital and physician(s) that includes a scope of service, remuneration, and term is required as the minimum supporting documentation for contracted physicians and/or mid-level professionals. Providers must also report all related revenues received for these costs. If the hospital does not report revenues on schedule 1 for these costs, adequate documentation from the provider to support how these services are billed for each payor group will be required or these costs will be disallowed.

If these costs are removed as A-8 adjustments to the hospital's general service cost centers, these costs should be reported on the General Services line (line 1) in Column 1.

If the hospital has costs for physicians and one or more types of mid-level professionals for a given cost center, the costs can be combined and the total reported in Column 1 provided the same allocation statistic will be utilized to apportion the costs to charity. If the hospital elects to utilize different allocation statistics to apportion the physician and/or any type of mid-level professional costs for a given cost center the cost center can be subscripted.

Column 1a – The recommended apportionment statistic for physician and/or mid-level professional costs is total billed professional charges by cost center. If a hospital does not maintain professional charges by payer type separately in its patient accounting system, then the professional costs can be apportioned based on total billed hospital departmental charges. Total billed hospital departmental charges by cost center are identified from the hospital's applicable Medicare cost report(s).

If professional charges related to the physician and/or mid-level professional services whose costs are reported in Column 1are utilized as the apportionment statistic, the professional charges must be from the same corresponding time period as the costs. The hospital must maintain adequate and auditable documentation to support the statistics reported in Column 1a.

If the hospital reports costs on the General Services line (Line 1) in Column 1, the recommended allocation statistic reported in Column 1a would be the aggregate total departmental charges (professional or hospital department, based on the apportionment statistic for the specific cost centers) for all cost centers.

Column 1b – The allocation basis the hospital elects to utilize to apportion the costs from Column 1 should be identified for each cost center. The approved allocation bases are total departmental professional charges if available. Otherwise departmental hospital charges may be utilized.

Column 2 - A cost to charge ratio (CCR) for each cost center is calculated by dividing the total costs for each cost center reported in Column 1 by the total allocation statistic for each cost center reported in Column 1a. If additional lines are added to Schedule 1, it will be necessary to copy the formula used to compute the CCR for the additional line(s). The CCR is carried out to six (6) decimal places.

Columns 2a & 2b - The applicable allocation statistics related to the physician and/or mid-level professional services provided to charity care patients are reported in Columns 2a and 2b based on the hospital's elected allocation basis reported in Column 1b. The allocation statistics applicable to charity care inpatient services are reported in Column 2a and allocation statistics applicable to charity care outpatient services are reported in Column 2b. The charity care inpatient and outpatient statistics should

be from the hospital's internal records and for the same fiscal period as the costs reported in Column 1 and total allocation statistics reported in Column 1a.

Columns 2c & 2d – The charity care inpatient and outpatient physician and/or mid-level professional costs are computed based on the CCR reported in Column 2 multiplied by the charity care inpatient and outpatient allocation statistics reported in Columns 2a and 2b, respectively. If additional lines are added to Schedule 1, it will be necessary to copy the formula used to compute the charity care inpatient and outpatient costs for the additional line(s).

All revenue received by the hospital related to physician and/or mid-level professional services provided inpatients and outpatients covered by charity care should be reported on Line 102 of the respective Columns 2c & 2d. The revenue will be subtracted from the respective costs to determine the net costs to be included in the hospital's UC Application.

Schedule 2

The schedule computes the pharmacy costs related to prescription drugs provided by hospitals participating in the Texas Vendor Drug program. These pharmacy costs are not related to services provided by the hospital's retail pharmacy or billed to a third party payer under revenue code 253. If the pharmacy costs were included in the hospital's Texas Medicaid DSH Application, they should not be included in the TXHUC application. If the pharmacy costs were included in the hospital's interim and/or final Hospital Specific Limit (HSL), they should not be included in Schedule 2 of the TXHUC application. Pharmacy costs should be related to drugs provided under either the hospital charity policy or the hospital pharmacy charity policy.

Column 1 - The total costs for the cost center that contains the drug costs related to the prescription drugs provided under the Texas Vendor Drug program are reported in Column 1, Line 1. These costs are from the hospital Medicare cost report(s) Worksheet B, Part I, last column for the applicable cost center.

Column 1a – The total hospital departmental charges for the cost center that contains the drug charges related to the prescription drugs provided under the Texas Vendor Drug program are reported in Column 1a, Line 1. These charges are from the hospital Medicare cost report(s) Worksheet C, Part I, Column 8 for the applicable cost center.

Column 1b – The allocation basis is hospital departmental charges. If the hospital wants to utilize an alternative allocation basis, they must submit a written request to Texas HHSC that identifies the alternative allocation basis and an explanation as to why the alternative allocation basis results in a more equitable apportionment of the pharmacy costs. HHSC will provide a written response to the hospital's request within 60 days of receiving the request and their decision is final.

Column 2 – The Cost-to-Charge ratio is computed by dividing the costs reported in Column 1 by the allocation statistic reported in Column 2. The CCR is carried out to six (6) decimal places.

Column 3a - The charges related to the prescription drugs provided to charity care patients under the Texas Vendor Drug program are reported in Column 3a, Line 1. These charges are obtained from the hospital's internal records. These charges should be for services provided during the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being

determined. The hospital must maintain the supporting documentation and submit it to HHSC upon request.

Column 3b – The costs related to the prescription drugs provided to Uninsured patients under the Texas Vendor Drug program are computed by multiplying the charges reported in Column 3a by the CCR computed in Column 2.

Line 2 - All revenue received by the hospital related to prescription drug services provided to charity care patients should be reported on Line 2 of the Columns 3b. This includes any rebates received from the Texas Vendor Drug program. The revenue will be subtracted from the cost to determine the net cost to be included in the hospital's UC Application.

Schedules 3 and 4

Schedule 3 determines the hospital charity care costs for the UC program for the applicable fiscal year (10/1/20XX – 9/30/20YY). HHSC will employ the same methodology used to compute the hospital-specific limit for the determination of the DSH Pool payments except that only charity care charges will be used to determine charity care costs for computing payments under UC. In addition, the Medicaid coverage limitations under Section 1905(a) of the Act, which exclude coverage for patients in an IMD who are under age 65, except for coverage of inpatient psychiatric hospital services for individuals under age 21, are applicable.

Hospitals must complete the Cost Report Collection Form worksheets in the TXHUC application to allow HHSC to compute their HSL. The source of charity charges for the calculation of allowable costs will be CMS 2552 Worksheet S-10 line 20 column 1 as reported on the Hospital Data 2 tab. Hospitals will be asked to report their associated charity care days that will be used to calculate per diem costs for charity care. Offsetting revenue for these costs will be obtained from CMS 2552 Worksheet S-10 line 22 column 1Non-S-10 hospitals will report their charity charges and charity care days on the Hospital Data 2 tab in accordance with the reporting requirements of the CMS 2552-10 S-10 instructions but will need to provide supporting schedules, including charity care days to HHSC.

Schedule 4 determines the hospital's Medicaid DSH costs (Medicaid shortfall and uninsured costs) and the Hospital-Specific Limit (HSL).

<u>Reconciliation of UC Payments to Hospitals</u>

As explained elsewhere in this protocol, UC payments to hospitals are determined utilizing the TXHUC, which is based on data for services furnished during the period two years before the demonstration year. In compliance with STC 33, HHSC reconciles the UC payments made in prior demonstration years to ensure that a hospital's payments did not exceed its actual eligible uncompensated costs incurred during that demonstration year. Payments in excess of actual eligible uncompensated costs are considered an overpayment to the hospital and will be recouped within one (1) year of the identified overpayment.

The reconciliation process utilizes a reconciliation survey that employs the same cost claiming methodology as the TXHUC to calculate uncompensated care costs (but which may have a format that is configured to interface with contractors' information technology systems), and the best available cost report or reports covering the demonstration year. If the hospital's cost report period does not coincide with the demonstration year being reconciled, it will be necessary to pro rate the data from the two cost

report periods that cover the demonstration year. HHSC will perform reconciliations for payments made during each year of the waiver.

At the beginning of the reconciliation process for each demonstration year, HHSC or its designee will notify each hospital that is subject to the reconciliation and will provide the hospital with a survey of costs and payments that is similar to the TXHUC described elsewhere in this protocol. The hospital is required to complete the reconciliation survey and cooperate with HHSC or its designee to complete the reconciliation. If a hospital fails to provide required information, HHSC will recoup any UC payment that is unsupported by the available data, up to the full amount of the UC payment made to the hospital during the demonstration year for which payments are being reconciled.

As part of the reconciliation process, HHSC or its designee will ensure that providers that received both DSH and UC payments in the period being reconciled did not receive total payments under the UC Pool (related to inpatient and outpatient hospital services provided to uninsured individuals as charity care) and under the DSH program that exceed the hospital's total actual eligible uncompensated costs for the demonstration year. For purposes of this requirement, "total eligible uncompensated costs" means the hospital's DSH hospital-specific limit (HSL) plus the uncompensated costs of non-covered inpatient and outpatient services provided to uninsured charity-care patients. UC payments attributable to physician and mid-level professional costs, pharmacy, and clinic costs are not considered inpatient or outpatient Medicaid payments for purposes of calculating total eligible uncompensated costs.

Before reconciling UC payments for hospitals that also participated in DSH, HHSC or its designee will calculate the final DSH HSL less the amount of DSH payments the hospital received in the same period. The hospital's UC payment associated with costs that are included in the DSH HSL calculation cannot exceed the remaining DSH HSL after the DSH payments have been calculated. In the event the UC payments related to costs in the DSH HSL and the DSH payments exceed the DSH HSL, the excess UC payment amount will be considered an overpayment and recouped. Costs and payments attributable to physician and mid-level professional services, pharmacy, and clinic services are not included for purposes of calculating total eligible uncompensated costs in this context.

Additionally, for IMDs that received payments in both DSH and UC, HHSC or its designee will calculate the total eligible uncompensated costs for services provided to the age-restricted population (under 21 and over 64). If the UC payments to the IMD exceed the lesser of the IMD's cost for providing services to the age-restricted population and the remaining DSH HSL after DSH payments, the excess UC payment amount will be considered an overpayment and recouped.

If, at the end of the reconciliation process, it is determined that a provider received an overpayment for any reason, the amount of the overpayment will be recouped from the provider and may be redistributed to hospitals that have UC room (in proportion to the amount of each hospital's UC room) or, alternatively, the federal share of the overpayment will be properly credited to the federal government through an adjustment shown on the CMS-64.

The reconciliation schedule is described in the section titled "Section 1115 Waiver UC Program Reconciliation Schedule" below.

Part 2: Physician Practice Groups

Texas Physician Uncompensated Care Application (TXPUC)

> The purpose of the TXPUC is to determine the physician professional costs related to services provided to charity care patients by physician organizations that may be reimbursable from the Uncompensated Care pool. Only professional organizations that previously participated in the Texas Medicaid Physician UPL ("Physician UPL") program or their successor organizations are eligible to submit a TXPUC and receive a distribution from the UC Pool. Under the Physician UPL, supplemental payments were made only for physician services performed by doctors of medicine and osteopathy licensed in Texas; furthermore, to remain eligible, all professionals, as defined below, must have a developed charity care policy that does not include bad debt, payment shortfall(s), insurance allowances, courtesy allowances, or discounts given to patients who do not meet the provider's charity care policy or financial assistance policy. Failure to have a written charity care policy will result in being ineligible for any UC payment.

All costs (direct and indirect) incurred by the physician organization related to services provided by mid-level professionals may also be reported on the physician organization's UC application.

For purposes of the TXPUC Application, a mid-level professional is defined as:

- Certified Registered Nurse Anesthetist (CRNA)
- Nurse Practitioner
- Physician Assistant
- Dentist
- Certified Nurse Midwife
- Clinical Social Worker
- Clinical Psychologist
- Optometrist

The TXPUC is based on established physician and/or mid-level cost finding methodologies developed by the Medicare program over the past 40 years. The schedules that follow use the same or similar methodology and worksheet identification process used by the Medicare hospital cost report.

For all the worksheets in the TXPUC, the cells requiring input are highlighted in green. All line numbers and descriptions are linked to Worksheet A. If lines are inserted, they must be inserted on all worksheets and in the same location.

The costs to be reported in the TXPUC are limited to identifiable and auditable compensation costs that have been incurred by the physician organization for services furnished by physicians and/or mid-level professionals in all applicable sites of service, including services provided in a hospital setting and non-hospital physician office sites for which the professional organization bills for and collects payment for the direct patient care services.

The basis for the total physicians' and/or mid-level professionals' compensation costs incurred by the professional organization will be the organization's general ledger. The costs should be representative of the services provided during the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined.

Total costs, reported by cost centers/departments, are then allocated between clinical and non-clinical activities using a CMS-approved time-study. The physician and/or mid-level professional time study forms to be used are located on the Texas Health and Human Service Commission website. Time studies

should be completed for a two (2) week period once per quarter during the fiscal year. Ideally, the time study period will not be the same two weeks in any 2 given quarters. The physician organization must utilize the CMS-approved time study to allocate physician and/or mid-level professional compensation costs between clinical and non-clinical activities. The result of the CMS-approved time study is the physicians' and mid-level professionals' compensation costs pertaining only to clinical, patient care activities. The physicians' and mid-level professionals' compensation costs are reduced by National Institute of Health (NIH) grants to the extent the research activities component is not removed via physician time studies.

The physician clinical and/or mid-level professional costs are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare cost principles. There will be an offset of revenues received for services furnished to non-patients and other applicable non-patient care revenues that were not previously offset or accounted for by the application of the CMS-approved time study.

The above physicians' and/or mid-level professionals' compensation costs must not be duplicative of any costs claimed on a hospital's TXHUC.

Additional costs that can be recognized as professional direct costs are costs for non-capitalized medical supplies and equipment (as defined in the instructions for Worksheet A, Column 3 below) used in the furnishing of direct patient care.

Overhead costs will be recognized through the application of a rate for indirect costs to be determined by the actual costs incurred by the physician organization for the applicable reporting period(s) included in the UC application. The determination of the facility-specific indirect rate is defined in the instructions for Worksheet A, Column 8 below. Other than the direct costs defined above and the application of an approved indirect rate, no other costs are allowed.

Total billed professional charges by cost center related to physician and/or mid-level professional services are identified from provider records.

The total professional charges for each cost center related to Medicaid fee-for-service (FFS), Medicaid managed care (HMO), and charity care physician and/or mid-level professional services, billed directly by the professional organization, are identified using auditable financial records. Professional charges related to services provided to out-of-State Medicaid FFS and HMO patients should be included in the Medicaid charges reported on the TXPUC. The professional organization must map the claims to the respective cost centers using information from their billing systems. Each charge must be mapped to only one cost center to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the TXPUC (the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined). The professional organization must prepare a worksheet that identifies professional charges related to physician and/or mid-level professional services provided to patients covered by Medicaid FFS, Medicaid HMO, uninsured and all other payers for each cost center to be used to report the total charges on Worksheet B and the Program charges on Worksheet D. The worksheet total charges must be reconciled to the total charges per the professional organization's general ledger and/or financial statements for the applicable fiscal period(s).

Professional organizations are expected to obtain a time study from each physician and/or mid-level professional to be used in the allocation of the physicians' and/or mid-level professionals' compensation costs to direct patient care services and other activities. The physician and/or mid-level professional time study forms to be used are located on the Texas Health and Human Services website. Time studies should be completed for a two (2) week period once per quarter during the fiscal year. Ideally, the time study period will not be the same two weeks in any two given quarters.

If a professional organization incurs costs for services provided by another entity under a contractual arrangement, those costs can be included. The professional organization would be required to offset the revenue received on its UC Application to eliminate any duplicate payment for the costs related to these services.

Certification

The certification page must be signed and dated by an officer or administrator of the provider. An officer is defined as a member of the entity's senior management such as the chief executive officer, chief financial officer, chief operating officer, etc. The certification must contain an original signature and not a copy or electronic signature.

Upon the termination of the 1115 Waiver, entities will be required to submit actual cost data in the prescribed format of the TXPUC for a minimum of two years for purposes of reconciling the UC Pool payments for the last two years of the Waiver with the provider's actual charity costs incurred for those fiscal periods

Summary Schedule

Column 1 - Summarizes the charity costs determined on the applicable columns from Worksheet D. These amounts will flow automatically from the respective columns and no input is required.

Column 2 – The distribution of the Uncompensated Care Pool ("UC Pool") for a specific demonstration year will be based on the costs for the period from October 1 through September 30 two years prior to the demonstration year as computed on Worksheet D. If the entity knows these costs are not representative of their actual costs for the demonstration year, due to changes in their contractual arrangements or other operational or economic issues, the entity can make an adjustment to these costs. The entity is required to maintain supporting documentation to support their adjustment amount and make this information available upon request from HHSC and/or CMS.

Column 3 – Represents the net charity costs after any adjustments and is determined by summing the amounts in Columns 1 & 2. The net cost amount will be utilized to determine the entity's distribution from the UC Pool.

Worksheet A

This worksheet is a summary of the allowable direct patient care costs for physicians and mid-level professionals. The worksheet is segregated into 3 sections. Lines 1 – 29 contain the costs for physicians and mid-level professionals for patient care services provided in a hospital-based setting. Lines 31 – 55 contain the costs for physicians and mid-level professionals for patient care services provided in a non-hospital-based setting. Lines 56 – 79 contain costs for physicians and mid-level professionals for patient care services provided in settings other than those identified in Sections 1 and 2.

Cost center descriptions are input on this worksheet and will flow to the other worksheets. If lines are

added to this worksheet to accommodate the professional organization's unique cost centers, similar lines will need to be added to the other worksheets.

The professional organization's name, provider number, reporting period and indirect cost rate should be input on this worksheet and will flow to the other worksheets.

Column 1 – Physicians' costs determined on Worksheet A-1 will flow to this column.

Column 2 – Mid-level professionals' costs identified A-2 should be mapped to the respective cost centers on Worksheet A.

Column 3 – Non-capital equipment and supplies costs related to direct patient care are input in this column. Non-capital equipment would be items such as the purchase of reusable surgical trays, scalpels or other medical equipment whose costs are expensed upon acquisition since they are below the organization's threshold for capitalization. Supplies would be items such as disposable supplies utilized during the treatment of patients (sutures, gauze pads, tape, bandages, needles and syringes, splints, etc.). The source for these costs is the professional organization's accounting records. The source for these costs must be maintained by the professional organization and submitted to HHSC or CMS upon request.

Column 4 – This column is the sum of Columns 1, 2 and 3. If line(s) have been added to the worksheet, it will be necessary to copy the formula in this column from an existing line to the line(s) that were added.

Column 5 – Any reclassification of costs reported on Worksheet A-6 will flow to this column.

Column 6 – This column is the sum of Columns 4 and 5. If line(s) have been added to the worksheet, it will be necessary to copy the formula in this column from an existing line to the line(s) that were added.

Column 7 - Any adjustments of costs reported on Worksheet A-8 will flow to this column. For example, revenue received for National Institute of Health (NIH) grants, to the extent the research activities component is not removed via physician and/or mid-level professional time studies should be reported on this Worksheet.

Column 8 – The indirect costs in this column are computed based on the costs reported in Column 6 multiplied by the indirect cost rate for the professional organization. The indirect cost rate will be determined based on the professional organization's actual indirect costs to its total direct costs (allowable and nonallowable) for the applicable reporting period(s) covered by the UC application. The professional organization's costs per its general ledger for the applicable fiscal period(s) should be used to identify the allowable direct and indirect costs to be used to compute the indirect cost rate. The indirect cost rate should be rounded to two (2) decimal places (e.g. 22.58%). The professional organization must submit its calculation of its indirect cost rate with its UC application.

Allowable indirect costs are defined as costs incurred by the professional organization in support of the physicians' and mid-level professionals' direct patient care services, regardless of the location where these services are performed. Medicare cost finding principles should be used to determine allowable indirect costs. Allowable indirect costs would include, but are not limited to, nurse staff and other support personnel salaries and fringe benefits involved in direct patient care, billing and administrative personnel salaries and fringe benefits related to direct patient care, space costs (building and equipment depreciation or lease, interest, utilities, maintenance, etc.) related to the space utilized to provide care to patients.

Nonallowable indirect costs would include but are not limited to; advertising for the purpose of increasing patient utilization, bad debts related to accounts receivable, gain or loss on the sale of depreciable assets, fines or penalties imposed by local, state or federal government or their agencies. Any fringe benefits cost related to the physicians' and mid-level professionals' compensation costs should be included in Columns 1 and/or 2 of Worksheet A should not be included in the allowable indirect costs. The non-capital equipment and supply costs reported in Column 3 of Worksheet A above should also be excluded from allowable indirect costs.

Total costs would be determined based on the professional organization's total expenses per its general ledger. The following is an illustrative example of the calculation of an indirect cost rate for a professional organization.

UC application reporting period	**10/1/2009 - 9/30/2010**	
Fiscal year end of professional organization	12/31/2009	12/31/2010
Total expenses per the general ledger	25,000,000	28,600,800
Bad Debts	(800,000)	(923,000)
Loss on sale of depreciable assets	(200,000)	(123,000)
N/A Advertising Expenses	(111,000)	(133,000)
Physician and mid-level professional compensation (from Col. 1)	(11,500,700)	(13,600,200)
Non capital equipment and supplies (from Col. 3)	(765,000)	(842,000)
Allowable Direct Expenses	(12,265,700)	(14,442,200)
Allowable indirect costs	11,623,300	12,979,600
Total direct costs	13,376,700	15,621,200
Indirect cost ratio	86.89%	83.09%
Weighted indirect cost ratio	21.72%	62.32%
Allowable indirect cost ratio		84.04%

Column 9 – This column is the total physicians' and mid-level professionals' costs that flow to Worksheet B, Column 1. It is the sum of Columns 6, 7 and 8. If line(s) have been added to the worksheet, it will be necessary to copy the formula in this column from an existing line to the line(s) that were added.

Worksheet A-6

This reclassification worksheet is similar to the Worksheet A-6 in the Hospital 2552 Medicare cost report. It allows for the reclassification of costs between cost centers reported on Worksheet A. Any reclassifications reported on this worksheet will need to be input on Worksheet A, Column 5 in the applicable line.

Worksheet A-8

This adjustments worksheet is similar to the Worksheet A-8 in the Hospital 2552 Medicare cost report. It allows for any required adjustment(s) to the costs reported on Worksheet A (e.g. NIH grant revenue if

research costs are not identified via the time studies). All payments received for services provided to another entity's patients should be offset against the applicable costs. All payments received from another entity to subsidize the care provided to a patient who was referred by the entity should be offset against the applicable costs. Any adjustments reported on this worksheet will need to be input on Worksheet A, Column 7 in the applicable line**.**

Worksheet B

The worksheet calculates the cost-to-charge ratio (CCR) to be utilized in apportioning the physicians' and/or mid-level professionals' compensation costs for services provided to Medicaid and Uninsured patients that is the basis for the determination of the professional organization's distribution from the UC Physician Pool. The CCR is carried out to six (6) decimal places.

Column 1 – The net physicians' and mid-level professionals' costs from Worksheet A, Column 8 will flow to this column.

Column 2 – The physicians' and/or mid-level professionals' total billed charges are reported in this column. As an alternative, the professional organization can use the number of visits as the allocation basis to apportion the costs. If the professional organization does elect to utilize patient visits to apportion the costs, the allocation basis reported at the top of this column should be changed from Total Billed Charges to Patient Visits. For either allocation basis, the source for this data will be the professional organization's internal records and will be representative of costs incurred in the period October 1 to September 30 two years prior to the demonstration year for which UC payments are being determined.

For purposes of the UC Application, a visit is defined as a face-to-face encounter between a patient and a physician and/or mid-level professional. Multiple encounters with the same physician and/or mid-level professional that take place on the same day and at a single location for the same diagnosis constitute a single visit. More than one visit may be counted on the same day (which may be at a different location) in either of the following situations:

a) When the patient, after the first visit, suffers illness or injury requiring another diagnosis or treatment, two visits may be counted.
b) When the patient is seen by a dentist and sees a physician and/or mid-level professional, two visits may be counted.

Column 3 – The CCR is computed by dividing the costs reported in Column 1 of this worksheet by the total allocation basis reported in Column 2 of this worksheet. The CCR is carried out to six (6) decimal places.

Worksheet D

This worksheet computes the physicians' and/or mid-level professionals' costs for services provided to Medicaid FFS, Medicaid HMO and Uninsured patients. It utilizes the CCR determined on Worksheet B, Column 3 and the charges for physician and/or mid-level professional services. The source for the Medicaid FFS, Medicaid HMO and Uninsured data are the professional organization's internal records and will be representative of costs incurred in the period October 1 to September 30 two years prior to the demonstration year for which UC payments are being determined. The allocation basis reported on Worksheet B Column 2 must be the same as the apportionment basis reported on Worksheet D, Columns

2 – 3. If the professional organization elects to utilize patient visits to apportion the costs rather than billed charges, the apportionment basis at the top of Columns 2 – 3 should be changed from Billed Charges to Patient Visits.

Column 1 – The CCR from Worksheet B, Column 3 flows to this column.

Columns 2 – 3 – The physicians' and mid-level professionals' costs for inpatient and outpatient services provided to uninsured charity care patients are computed by multiplying the CCR reported in Column 1 multiplied by the apportionment statistics reported in Columns 2 – 3 for the respective columns.

The total costs for each column are determined at the bottom of the worksheet. All revenues received from any source related to the physician and/or mid-level professional services provided to uninsured charity care patients should be reported on the Less Payments line at the bottom of the worksheet in the respective column.

The Net Unreimbursed Cost for Columns 4 and 5 flows to the Cost Summary worksheet of the TXPUC tool. This cost will be utilized to determine the professional organization's distribution from the UC Physician Pool.

Reconciliation of UC Payments to Professional Organizations

As explained above, the professional organization's UC payments are determined using the TXPUC that captures data for the fiscal period October 1 through September 30 two years before the demonstration year. In compliance with STC 33, HHSC reconciles the UC payments made in prior demonstration years to ensure that the professional organization's payments did not exceed its actual eligible uncompensated costs incurred during that demonstration year. Payments in excess of actual eligible uncompensated costs are considered an overpayment to the hospital and will be recouped.

The UC payments are reconciled using data on the professional organization's TXPUC for the demonstration year two years after the year the payments were made. Once the TXPUC for the expenditure year has been finalized by the State, a reconciliation of the finalized costs to all UC payments made for the same period will be performed.

If, at the end of the reconciliation process, it is determined that a professional organization received an overpayment, the amount of the overpayment will be recouped from the provider and may be redistributed to professional organizations that were determined to be underpaid (in proportion to the amount of each professional organization's underpayment) or the federal portion of the overpayment will be properly credited to the federal government through an adjustment shown on the CMS-64.

The timelines for the submission of reconciliations are detailed in the "Section 1115 Waiver UCC Program Reconciliation Schedule" below.

Section 1115 Waiver UC Program Reconciliation Schedule

HHSC will complete the reconciliation process for hospitals and professional organizations no later than December 31 of the calendar year that is three years after the demonstration year. For example, for DY 9 (October 1, 2019, to September 30, 2020) the reconciliation process should be completed by December 31, 2023. (This is the same timeline required by CMS for completion of the federally-required DSH

audit.) HHSC will comply with federal requirements for completing the process of recouping and redistributing the overpaid amounts or crediting the federal share through an adjustment on the CMS 64.

Part 3: Government Dental Providers

General:

Governmentally owned dental providers are eligible to participate in the supplemental payment program if they are directly funded by a local government, hospital authority, hospital district, city, county or state as specified in 42 CFR § 433.50 (i) which describes a unit of government. This would include providers such as public health clinics and departments, dental schools, mobile dental units or other dental facilities that are owned by the government. Providers wanting to participate in the program should contact the Texas Health and Human Services Commission (HHSC), Rate Analysis Department at 512-730-7401.

The Dental Services Supplemental Payment Cost Report (cost report) must be prepared and completed on an annual basis. Cost reports are due to HHSC 180 days after the close of the applicable reporting period. An eligible provider who has been approved to submit a cost report for supplemental payment will prepare the cost report, attest to and certify the total actual and charity charges and costs/expenditures. The completed cost report will be sent to:

HHSC Provider Finance Department
North Austin Complex
4601 W Guadalupe St.
Mail Code H-400
Austin, Texas 78751

When using the Excel spreadsheet, many fields in the exhibits will automatically populate with information from another worksheet to avoid additional data entry and reduce errors. Therefore, only the **SHADED AREAS** of the cost report are to be completed. Please review and verify the accuracy of all information on the exhibits before completing the report.

For questions on completing the cost report, please contact the Health and Human Services Commission, Rate Analysis Department at 512-730-7401.

Definitions:

Charity Care - Charges or costs associated with provision of services to individuals under the provider's charity care policies that do not establish any amounts owed by the patient and do not include bad debt, payment shortfall(s), insurance allowances, courtesy allowances, or discounts given to patients who do not meet the provider's charity care policy or financial assistance policy

Cognizant agency - the agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals developed in accordance with the Office of Management and Budget Circular A-87.

Commercial Pay Insurance - health insurance that covers medical expenses and disability income for the insured. Commercial health insurance can be categorized according to its renewal provisions and type of medical benefits provided. Commercial policies can be sold individually or as part of a group plan.

Cost Allocation Plans - are the means by which costs are identified in a logical and systematic manner for reimbursement under federal grants and agreements.

Cost-to-charge-ratio (CCR) - a provider's reported costs are allocated to the Medicaid program based on

a cost-to-billed-charge ratio. Cost-to- billed charge ratio is calculated as total allowable cost reported for the service period divided by total billed charges for the service period. This ratio is then applied to total billed charges associated with charity claims to calculate total allowable billed costs for the cost report. The CCR is carried out to six (6) decimal places.

Direct Cost - means any cost which is identified specifically with a particular final cost objective. Direct costs are not limited to items which are incorporated in the end product as material or labor. Costs identified specifically with a contract are direct costs of that contract. All costs identified specifically with other final cost objectives of the contractor are direct costs of those cost objectives.

Federal Medical Assistance Percentage (FMAP) - the share of state Medicaid benefit costs paid for by the federal government.

Indirect Costs - cost incurred and identified with having two or more cost objectives but not specifically identified with any final cost objective.

Indirect Cost Rate - a device for determining in a reasonable manner the proportion of indirect costs each program should bear. It is the ratio, expressed as a percentage, of the indirect costs to the direct costs.

Intergovernmental Transfers (IGT) - State and local funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity and eligible for federal match under the 1115 Transformation Waiver. This does not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

Medicare - a federal system of health insurance for those who are 65 and older, disabled or have permanent kidney failure.

Self-Pay - an individual who either does not have insurance or her/his insurance does not cover a particular procedure or provider and therefore, the individual is responsible for paying the provider.

Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver - the vehicle approved by HHSC and CMS for implementation of the waiver program under section 1115 of the Social Security Act.

Uninsured - an individual who has no health insurance or other source of third-party coverage for medical/health services.

Uninsured cost - the cost to provide dental services to uninsured patients as defined by the Centers for Medicare and Medicaid Services. An individual whose third-party coverage does not include the service provided is considered by HHSC to be uninsured for that service.

Unit of government - a state, city, county, special purpose district or other governmental unit in the State that: has taxing authority, has direct access to tax revenues, is a State university teaching hospital with

direct appropriations from the State treasury, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act, as amended (25 U.S.C. 450b).

Exhibit 1: Cover Page

Exhibit 1 is the cost report cover page. This form includes a provider's national and state provider identification numbers. Each governmental provider enters its legal name and the appropriate contact information for all parties listed on the form. This information will be used by HHSC to contact the provider during the cost reconciliation and settlement process.

DIRECTIONS TO COMPLETE EXHIBIT 1

Federal Fiscal Year: Enter the federal fiscal year for which the cost report will be completed (e.g., 2012). When this is entered on the cover page, this field will automatically transfer to subsequent exhibits.

Reporting Period: Enter the actual reporting period for which the cost report will be completed (e.g., 10/01/11 to 09/30/12). When this is entered on the cover page, this field will automatically transfer to subsequent exhibits.

Texas Provider Identification Number (TPI): Enter the 9-digit TPI number for the provider that is completing the cost report. When this is entered on the cover page, this field will automatically transfer to subsequent exhibits.

National Provider Identification Number (NPI): Enter the 10-digit NPI number for the provider that is completing the cost report. When this is entered on the cover page, this field will automatically transfer to subsequent exhibits.

Provider Information

Provider Name: Enter the provider's legal name (e.g., Laredo Health Department Dental Clinic)

Provider Contact Name: Enter the provider's contact

Street Address: Enter the street address and also include the city, state, and zip code in this field.

Mailing Address: Enter the mailing address and also include the city, state, and zip code in this field.

Phone Number: Enter the phone number of the provider's contact.

Fax Number: Enter the fax number of the provider's contact.

Email: Enter the email of the provider's contact.

Chief Financial Officer / Business Manager

Name: Enter the name of the chief financial officer or business manager.

Title: Enter the title of the chief financial officer or business manager.

Business Name: Enter the business name (e.g. UT Health Science Center at San Antonio Dental School).

Mailing Address: Enter the mailing address and also include the city, state, and zip code in this field.

Phone Number: Enter the phone number of the chief financial officer or business manager.

Fax Number: Enter the fax number of the chief financial officer or business manager.

Email: Enter the email of the chief financial officer or business manager.

Report Preparer Identification
Name: Enter the name of the person responsible for preparing the cost report (this is the person HHSC should contact if there are questions).

Title: Enter the title of the report preparer.
Business Name: Enter the business name (e.g. UT Health Science Center at San Antonio Dental School).

Mailing Address: Enter the mailing address and also include the city, state, and zip code in this field.

Phone Number: Enter the phone number of the report preparer.

Fax Number: Enter the fax number of the report preparer.

Email: Enter the email of the report preparer.

Location of Accounting Records that Support this Report. Enter the Physical Address of the location where the provider maintains the accounting records that support the cost report and include the city, state, and zip code in this field. When this is entered on the cover page, this field will automatically transfer to the subsequent exhibits.

Exhibit 2: General and Statistical Information

Directions To Complete Exhibit 2
Exhibit 2 is the General and Statistical Information page of the cost report. This exhibit includes general provider and statistical information used in the cost report.

General Provider Information
1.00-1.03: These fields will automatically transfer from the Exhibit 1.

1.04 : Enter either yes or no to indicate if the reporting period is less than a full federal fiscal year. If the cost report is being prepared for a partial fiscal quarter, enter a response that explains the reason why (e.g., no, Supplemental Payment Request Approval was effective beginning 3/1/20XX).

Cost Allocation Information
The purpose of this section is to obtain summary information regarding the cost allocation methodology the governmental entity utilized to allocate costs to various programs, grants, contracts and agreements. Additional information required to support an agency's methodology will be found on Exhibit 7 Worksheet C.

1.05 : Enter either yes or no to indicate whether your agency has an approved Cost Allocation Plan (CAP). Additional information must be provided on Exhibit 7 Worksheet C.

1.06 : If the answer to 1.05 is yes, enter the name of the Cognizant Agency.

1.07 : Enter yes or no to indicate whether your agency has an approved Indirect Cost Rate (IDCR).

1.08: If the answer to 1.07 is yes, enter the name of the Cognizant Agency.

1.09: Enter either yes or no to indicate whether your agency will be using an IDCR on this report.

1.10: If the answer to 1.09 is yes, enter the IDCR Statistical Information.

1.11 : Charity Care Charges Amount: Enter the total charges associated with charity care provided during the cost report period.

1.12 : Charity Care Reimbursement: Enter the total payments received associated with the charity care charges reported on line 1.11.

1.13 : Total Allowable Costs for Reporting Period: This field will automatically transfer from Exhibit 3 – Dental Cost Settlement, 2.40).

1.14 : Total Billed Charges: This field will automatically add the total charges for the cost report year.

Exhibit 3: Dental Cost Settlement

Directions To Complete EXHIBIT 3

Exhibit 3 identifies and summarizes all dental services costs. Much of the information contained within this exhibit is automatically populated from other exhibits; however, there are unique items of cost that must be entered in this exhibit.

Only allocable expenditures related to Uncompensated Charity Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program will be included for supplemental payment.

Direct cost methods must be used whenever reasonably possible. Direct costing means that allowable costs, direct or indirect, incurred for the benefit of, or directly attributable to, a specific business component must be directly charged to that particular business component. Direct cost accounting may include:

1. Dedicated Cost Centers: Cost may be included for those cost centers that are solely dedicated to Uncompensated Charity Care.
2. Multiple Cost Centers: Cost may be included for those cost centers that are not solely dedicated to Uncompensated Charity Care. However, the provider must submit a detailed approved Cost Allocation Plan (CAP). If cost allocation is necessary for cost-reporting purposes, governmental providers must use reasonable methods of allocation and must be consistent in their use of allocation methods for cost-reporting purposes across all program areas and business entities. The allocation method should be a reasonable reflection of the actual business operations. Allocation methods that do not reasonably reflect the actual business operations and resources expended toward each unique business entity are not acceptable. Allocated costs are adjusted if HHSC considers the allocation method to be unreasonable. The provider must submit a detailed summary of their cost allocation methodology including a description of the components, the formula for calculating the percentage and any additional supporting documentation as required by HHSC. Supplemental schedules must also be attached to the cost report listing each

employee, job title, total salary and benefits, the applicable allocation percentage and the allocation amount that will be included in the cost report. The amounts from the supplemental schedule allocated to the Medicaid and Uncompensated Care programs should match the amounts entered on Exhibit 6 Worksheet B with additional detail entered on Exhibit 7 Worksheet C.

If Indirect Cost (IDC) is included, that amount should be listed in line 2.30 (Other) with the detail described in either the Explanation Box or as a separate attachment. Indirect cost is calculated by multiplying the **Total Allowable** costs by the provider's approved indirect cost rate. IDCR detail should include the methodology for determining the IDCR, the percentage and amount of the IDCR and if the dental provider is already using the IDCR to claim cost on another report. If IDCR costs are claimed in line 2.30, indirect or administrative costs cannot also be claimed as non-clinical cost in lines 2.26 a., 2.27 a. or in administrative salaries and compensation in Exhibit 6 (Worksheet B). IDCR costs may be disallowed if it is determined that the provider has already claimed those same IDCR costs on this or another report. Additional detail regarding an agency's IDCR must be provided on Exhibit 7 Worksheet C.

This exhibit sums the payroll expenses and adds other costs to calculate the total cost of dental services. Identified reductions, either from Exhibit 6 or entered manually with descriptions in the Explanation Box, are subtracted to calculate the adjusted amount of dental costs allowable as part of the cost report. The cost report identifies the portion of allowable costs that are related to Charity Care and applies the cost-to-charge-ratio applicable for the cost report period. This ratio is applied to billed charges associated with Uncompensated Charity Care billed charges resulting in the total computable amount for dental services. This amount is then reduced by any reimbursement received for Uncompensated Charity Care. The resulting amount is then multiplied by the applicable federal medical assistance percentage (FMAP) to calculate the Federal and non-federal share amounts. The exhibit is separated into the sections identifying:

Personnel/Payroll Expenses
2.00-2.21: If using hours as an allocation method enter the number of hours. Total paid hours include but are not limited to regular wage, sick and vacation hours. If personnel/payroll expenditure data is entered on Exhibit 6 – Worksheet B – Payroll and Benefits, those costs will automatically transfer to this exhibit.

2.22 : State Unemployment Payroll Taxes: Enter the total (if applicable).

2.23 : Federal Unemployment Payroll Taxes: Enter the total (if applicable).

2.24 : Unemployment Compensation (Reimbursing Employer): Enter the total (if applicable).

2.25 : Total Staff Costs: Will automatically calculate (sum of applicable items in 2.00-2.24).

Other Costs
2.26 : Supplies and Materials: Supplies and materials include but are not limited to dental and medical supplies, office supplies, and maintenance supplies. Supplies and materials must be separated according to whether they are non-clinical or clinical. The total for non-clinical supplies and materials would be entered on 2.26 a. and the total for clinical supplies and materials would be entered on 2.26 b. Detail describing the supplies and materials along with the amount and allocation methodology should be entered in the Explanation Box or attached as a separate sheet. If a cognizant-agency- approved indirect cost rate is used, additional administrative (non-clinical) cost will not be permitted.

2.27 : Equipment: Equipment costs include but are not limited to dental and medical equipment, computers and communication equipment. Equipment costs must be separated according to whether they

are non-clinical or clinical. The total for non-clinical equipment would be entered on 2.27 a. and the total for clinical equipment would be entered on 2.27 b. Details describing the equipment costs along with the amount and allocation methodology should be entered in the Explanation Box or attached as a separate sheet. If a cognizant-agency-approved indirect cost rate is used, additional administrative (non-clinical) cost will not be permitted. If equipment and depreciation costs are already claimed as indirect costs or through the cost allocation plan, such costs cannot be claimed again in this section.

2.28 : Support Services: Enter the total and provide detail in the Explanation Box. Support services expenditures may include personnel and non-personnel expenditures such as information technology salaries and benefits and operating expenditures.

2.29 : Depreciation: Depreciation information should first be entered on Exhibit 5 – Schedule A – Depreciation and those costs will automatically transfer to this line. If equipment and depreciation costs are already claimed as indirect costs or through the cost allocation plan, such costs cannot be claimed again in this section.

2.30 : Other: Enter the total and provide detail in the Explanation Box.

2.31 : Total Direct and Indirect Dental Other Costs: Will automatically calculate (sum of 2.26 through 2.30).

2.32 : Total Staff, Direct and Indirect Dental Other Costs: Will automatically calculate (sum of 2.25 and 2.31).

Reductions

2.33 : Other Federal Funds and Grants: If expenditure data is entered on Exhibit 6 – Worksheet B Payroll and Benefits, those costs will automatically transfer to this line.

2.34 : Other: Enter the total and provide detail in the Explanation Box.

2.35 : Total Reductions: Will automatically calculate (sum of 2.33 and 2.34).

Cost Settlement Calculation

2.40 : Total Allowable Costs: Will automatically calculate (2.32 less 2.35).

2.41 : Total Billed Charges: This field will automatically transfer from Exhibit 2 – General & Statistical, 1.19.

2.42 : Cost-to-Charge-Ratio (CCR) = Total Allowable Costs/Total Billed Charges: Will automatically calculate (2.40 divided by 2.41) The CCR is carried out to six (6) decimal places.

2.43 : Total Billed Charges Associated with Charity Care: This field will automatically transfer from Exhibit 2 – General & Statistical, (sum of 1.06 and1.08).

2.44 : Charity Care Cost = CCR * Total Billed Charges Associated with Uncompensated Charity Care: Will automatically calculate (2.42 multiplied by 2.43).

2.45 : 2.46: Charity Care Reimbursement: Any reimbursement received for providing services to individuals under Charity Care.

2.47 : Settlement Amount = Total Uncompensated Charity Care Charges minus payments associated with Uncompensated Charity Care: Will automatically calculate 2.45 minus 2.46

2.48 : FMAP (Federal Medical Assistance Percentage): HHSC will enter the correct FMAP.

2.49 : Federal Funds = Settlement Amount * FMAP: Will automatically calculate (2.47 multiplied by 2.48).

2.50 : Non- Federal Share Funds (IGT Amount): Will automatically calculate 2.47 less 2.49). Governmental entities are required to certify on Exhibit 4 Cost Report Certification that they have completed the appropriate documentation required by HHSC and the Texas Comptroller's Office regarding the Intergovernmental Transfer (IGT) process. Once the cost report has been reviewed and accepted by HHSC, the provider will be notified of the amount required for the IGT.

Exhibit 4 – Cost Report Certification

Directions To Complete EXHIBIT 4
Exhibit 4 is the certification of costs included in the cost report. This form attests to and certifies the accuracy of the financial information contained within the cost report and that the report was prepared in accordance with State and Federal audit and cost principle standards. The signer is also certifying that the expenditures included in this cost report have not been claimed on any other cost report.

Most of the information in Exhibit 4 will be updated automatically with information from previous exhibits. This exhibit must be signed and included **UPON COMPLETION OF ALL OTHER EXHIBITS**.

Upon completion of all other exhibits in the cost report, please have the appropriate person read and sign the form. **Scan and include the signed page from Exhibit 4** when sending the electronic version of the cost report to HHSC.

Signature Authority/Certifying Signature
Printed/Typed Name of Signer: Enter the name of the person that will be certifying the costs identified in the cost report.

Title of Signer: Enter the title of the signer.

Name of Provider: Enter the name of the Provider.

Address of Signer: Enter the address of the signer.

Phone Number: Enter the phone number of the signer.

Fax Number: Enter the fax number of the signer.

Email: Enter the email of the signer.

Signature of Signer and Date: The signer should sign and date the form.

Exhibit 5 – Schedule A - Depreciation

Directions To Complete EXHIBIT 5
Exhibit 5 identifies allowable depreciation expenses incurred by the provider. This exhibit will identify all depreciable assets for which there was a depreciation expense during the Cost Report period. Information on this exhibit must come from a depreciation schedule maintained by the provider in accordance with straight line depreciation guidelines.

Vehicles, Equipment, Building, Etc.

For depreciation expenses, the straight line method should be used.

Asset Description: Enter the name and description of the asset. If there is the need to add additional lines, please do so.

Month/Year Placed in Service: Enter the month/year placed in service as identified on the provider's depreciation schedule.

Years Useful Life: Enter the number of years of useful life of the asset.

Cost: Enter the amount of initial cost.

Prior Period Accumulated Depreciation: Enter the amount of prior period accumulated depreciation.

Depreciation for Reporting Period: Enter the amount of current period depreciation expense.

Years Useful Life: Enter the number of years of useful life of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost: Enter the amount of initial cost of the asset as identified on the provider's depreciation schedule.

Prior Period Accumulated Depreciation plus Depreciation for Reporting Period cannot exceed the total cost of an asset. In addition, assets that have been fully expensed should not be reported. For depreciation expense related to buildings where the provider's vehicles or staff is housed with other agencies or entities, **ONLY the portion related to the provider** may be reported. If this is the case, the provider must attach a supplemental page showing how the portion of the building related to the provider was calculated. If equipment and depreciation costs are already claimed as indirect costs or through the cost allocation plan, such costs cannot be claimed again in this section.

Exhibit 6 – Worksheet B – Payroll and Benefits

Directions To Complete EXHIBIT 6

Exhibit 6 includes the salary and benefits, and appropriate reductions for contract and employed staff related to the provision of dental services. Salary and compensation must be reported on a direct charge basis. This exhibit includes several pre-populated staffing classifications for which information will need to be completed. If these costs are already claimed as indirect costs or through the cost allocation plan, such costs cannot be claimed again in this section. These pre-populated classifications include:

Director: salary and benefit expenditures related to developing, administration, and overall operational effectiveness of the organization including strategic planning, leadership and oversight, including but not limited to:

- Director
- Director's Assistant

Dental Director: salary and benefit expenditures related to planning, developing, scheduling, and the implementation of dental program services and activities, including but not limited to:

- Dental Director
- Dental Director's Assistant

Dentists and Dental Assistants: salary and benefit expenditures related to dental care including but not limited to:

- Dentists
- Dental Assistants

Safety Officer:

- Safety Officer
- Safety Officer Assistants

Billing Account Representatives: salary and benefit expenditures related to verification of patients' insurance coverage, including Medicaid, collection of third party insurance submissions and payments, and patient service related tasks, including but not limited to:

- Billing Representatives
- Account Representatives
- Patient Account Representative

Quality Assurance Technicians: salary and benefit expenditures related to analyzing performance and quality improvement program including but not limited to:

- Quality Assurance Technicians

For each employee, the following information must be included:

Employee Information

Employee #: Enter the employee #.

Last Name: Enter the last name.

First Name: Enter the first name.

Job Title/ Credentials: Enter the job title/credentials.

Employee (E) /Contractor (C): Enter the appropriate designation, either an E or a C, for the employee.

Payroll and Benefits

Gross Salary: Enter the gross salary amount.

Contractor Payments: Enter the amount of contractor payments for the employee.

Employee Benefits: Enter the amount. This includes all benefits that are not discretely identified in Columns J-L of this exhibit.

Employer Retirement: Enter the amount.

FICA: Enter the amount of FICA.

Medicare Payroll Taxes: Enter the amount.

Federal Funding Reductions
This section of the exhibit is designed to identify the federal funding, or other payroll and benefit expenditure reduction necessary for the specific job classifications identified above. This section of the exhibit is also designed to discretely identify the payroll and benefit expenditures for any individual employee/contractor that must have a portion of their salary and/or benefits reduced from allowable expenditures on the Cost Report. For each of the job classifications identified above, the following information must be included:

Allocated Funded Positions Entry: Enter the appropriate designation, either yes or no, for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. A yes in this field designates an employee for which a portion or all of their salary and benefit expenditures are funded by federal funds or grants. A "no" in this field designates an employee whose entire salary or a portion of whose salary and benefit expenditures are not funded by federal funds or grants, but whose costs still need to be removed from allowable expenditures as reported on the Cost Report.

Federal Funding: If the answer to the field previously is yes, then enter the amount of federal funding related to the employee's salary and benefits that must be reduced from the total allowable costs.

Other Funds: Enter the other amount to be removed related to the employee's salary and benefits that must be reduced from the total allowable costs.

Total Reduction: Will automatically calculate (sum of federal funding and other funds).

Exhibit 7 – Worksheet C – Cost Allocation Methodologies

Directions To Complete EXHIBIT 7
Exhibit 7 details the cost allocation methodologies employed by the governmental entity.

a. If you entered "yes" on Exhibit 2, Line 1.05, please provide a copy of your agency's approved Cost Allocation Plan (CAP).
b. If you entered "yes" on Exhibit 2, Line 1.06 and 1.09, please provide a copy of your agency's approved Indirect Cost Rate (IDCR).
c. If you do not have an approved CAP or IDCR but are using another cost allocation methodology, please provide a copy of your methodology and the supporting documentation.
d. Please provide a list of personnel cost worksheets that support your CAP or IDCR.

Attachment H
UC Payment Protocol

Appendix A - List of Participating Providers

University of Texas at San Antonio Health Science Center (UTHSC-SA) Dental School: performs the patient billing activities for the dental school, the mobile dental unit, the Ricardo Salinas Dental Clinic and the Laredo Health Department Dental Clinic.

Houston Health Department Dental Clinic

Part 4: Government Ambulance Providers

General

Governmentally owned ambulance providers are eligible to participate in the supplemental payment program if they are directly funded by a local government, hospital authority, hospital district, city, county or state as specified in 42 CFR § 433.50 (i) which describes a unit of government, and must have a developed charity care policy that does not include bad debt, payment shortfall(s), insurance allowances, courtesy allowances, or discounts given to patients who do not meet the provider's charity care policy or financial assistance policy. Failure to have a formal charity care policy will result in being ineligible for any UC payment. This would include providers such as public health clinics and departments.

The cost report will include only allocable expenditures related to charity care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program.

The Ambulance Services Supplemental Payment Cost Report (cost report) must be prepared and completed by a governmental entity on an annual basis. Cost reports are due to HHSC 180 days after the close of the applicable reporting period. A provider who meets the definition of eligible governmental provider and who has been approved to submit a cost report for supplemental payment will prepare the cost report and will attest to, and certify through its cost report the total actual, incurred charity costs/expenditures, including the federal share and the non-federal share applicable to the cost report period. The completed cost report will be sent to the Texas HHSC at

HHSC Provider Finance Department
North Austin Complex
4601 W Guadalupe St
Mail Code H-400
Austin, TX 78751

When using the Excel spreadsheet, many fields in the pages will automatically populate with information from another worksheet to avoid additional data entry and reduce errors. For the cost report to be accurate, only the **SHADED AREAS** of the cost report are to be completed. Please review and verify the accuracy of all information on the pages before completing the report.
For questions on completing the cost report, please contact the Health and Human Services Commission, Provider Finance Department at 512-424-6930.

Definitions:

Ambulance Allocation Statistic – an allocation percentage that is calculated by taking total ambulance services time divided by total ambulance and fire and emergency department time during the data period to allocate ambulance specific costs in situations when there are joint ambulance and fire and emergency department costs.

Charity Care - charges or costs associated with provision of services to individuals under the provider's charity care policies that does not include bad debt, payment shortfall(s), insurance allowances, courtesy allowances, or discounts given to patients who do not meet the provider's charity care policy or financial assistance policy.

Cognizant agency – agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals developed in accordance with the Office of Management and Budget Circular A-87.

Cost Allocation Plans – are how costs are identified in a logical and systematic manner for reimbursement under federal grants and agreements. The purpose of the Cost Allocation Plan is to ensure costs benefiting multiple fund sources (including Federal, State, and Entity) are distributed fairly among each fund source based on the benefits received.

Cost-to-charge ratio – a provider's reported costs are allocated to the Medicaid program based on a cost-to-billed-charge ratio. Cost-to-billed-charge ratio is calculated as total allowable cost reported for the service period divided by total billed charges for the service period. This ratio is applied to total charity charges to calculate total computable charity costs for the cost report.

County/City Indigent Programs – programs that help low-income residents who do not qualify for other state or federal health care programs to get access to health care services.

Direct Cost – means any cost which is identified specifically with a particular final cost objective. Direct costs are not limited to items which are incorporated in the end product as material or labor. Costs identified specifically with a contract are direct costs of that contract. All costs identified specifically with other final cost objectives of the contractor are direct costs of those cost objectives.

Direct Medical Services-health care provided by a licensed or certified provider to a patient.

Direct Medical Utilization Percentage – an allocation percentage that is calculated by taking the sum of direct medical services time during the data period divided by total Ambulance time during the data period. The calculation must be supported by verifiable computer-aided dispatch (CAD) or time studies data.

Federal Medical Assistance Participation (FMAP) Rate – is the share of state Medicaid benefit costs paid for by the federal government.

Indirect Costs – costs incurred and identified with having two or more cost objectives but not specifically identified with any final cost objective. Examples of indirect costs are accounting and legal expenses, administrative salaries, office expenses, rent, security expenses, telephone expenses, and utilities.

Indirect Cost Rate – is a device for determining in a reasonable manner the proportion of indirect costs each program should bear. It is the ratio, expressed as a percentage, of the indirect costs to the direct costs.

Modified Total Direct Cost – means all direct salaries and wages, applicable fringe benefits, materials and supplies, services, travel, and subawards and subcontracts up to the first $25,000 of each subaward or subcontract (regardless of the period of performance of the subawards and subcontracts under the award). MTDC excludes equipment, capital expenditures, charges for patient care, rental costs, tuition remission, scholarships and fellowships, participant support costs and the portion of each subaward and subcontract in excess of $25,000. Other items may only be excluded when necessary to avoid a serious inequity in the distribution of indirect costs, and with the approval of the cognizant agency for indirect costs in accordance with CFR § 200.68 .

Uninsured – an individual who has no health insurance or other source of third-party coverage for medical/health services.

Uninsured cost – the cost to provide ambulance services to uninsured patients as defined by the Centers for Medicare and Medicaid Services (CMS). An individual whose third-party coverage does not include the service provided is considered by HHSC to be uninsured for that service. Ambulance providers treat costs of uninsured patients (less any payments received) as charity costs.

Medicare – A federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.

Other third-party coverage

Commercial Pay Insurance – health insurance that reimburses medical expenses and disability income for the insured. Commercial health insurance can be categorized according to its renewal provisions and type of medical benefits provided. Commercial policies can be sold individually or as part of a group plan.

Self-Pay - patient pays in full at the time of visit for our services. Ambulance providers are not required to file claim or submit any documentation on his/her behalf to a third party.

Unit of Government - a state, city, county, special purpose district or other governmental unit in the State that: has taxing authority, has direct access to tax revenues, is a State university teaching hospital with direct appropriations from the State treasury, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act, as amended (25 U.S.C. 450b).

Exhibit A: Cost Report Cover Page

Exhibit A is the cost report cover page. This form includes a provider's National and State Provider Identification number. Each governmental provider must enter their entities legal name, name of person responsible for submitting the cost report, the cost preparers name and physical location, mailing address, phone number and fax number of all contacts listed. The information will be used by HHSC to contact the provider as necessary through the cost reconciliation and cost settlement process.

Fiscal Year:	Enter the federal fiscal year for which the cost report will be completed (e.g., 2010).

Reporting Period: Enter the actual reporting period for which the cost report will be completed (e.g., 10/01/10 to 09/30/11).

Texas Provider Identification Number (TPI): Enter the 9-digit TPI number for the provider that is completing the cost report (e.g., 1234567-89).

National Provider Identification Number (NPI): Enter the 10-digit NPI number for the provider that is completing the cost report (e.g., 1234567890).

Provider Information

Provider Legal Name Enter the provider's legal name (e.g., (Health and Human Services Commission EMS). This is the name of the provider completing the cost report.

Street Address: Enter provider street address (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78758). Include the city, state, and zip code in this field.

Mailing Address: Enter provider mailing address (e.g., 11209 Metric Blvd., Building H., Austin, Texas 78758 or P.O. Box 85700, Mail Code H-360, Austin, Texas 78708-5200). Include the city, state, and zip code in this field.

Phone Number: Enter the phone number of the provider's contact (e.g., (512) 123-4567).

Fax Number: Enter the fax number of the provider's contact (e.g., (512) 987-6543).

Email Address: Enter the email address of the provider's contact (e.g., iampublic@xyzabc.com).

Business Manager / Financial Director

Business Manager/Financial Directors Name: Enter the name of the business manager or financial director of the provider (e.g., Jane Doe).

Title: Enter the title of the business manager or financial director of the provider identified in the field above (e.g., Director).

Email Address: Enter the email address of the provider's contact (e.g., jqpublic@xyzabc.com).

Report Preparer Identification

Report Preparer Name: Enter the name of the provider's contact or person responsible for preparing the cost report (e.g., Jane Doe). This is the name of the person that HHSC may contact if there are questions.

Title: Enter the title of the provider's contact identified in the field above (e.g., Director).

Location of Accounting Records that Support this Report

Records Location: Enter the physical address of the location where the provider maintains

the accounting records in support of the cost report (e.g., 11209 Metric Blvd., Bldg. H., Austin, Texas 78758). Include the city, state, and zip code in this field.

Exhibit 1: General and Statistical Information

Exhibit 1 is the General and Statistical Information page of the cost report. This exhibit includes general provider information and statistical information used in the cost report.

DIRECTIONS TO COMPLETE EXHIBIT 1

General Provider Information

Reporting Period: Begin Date: Enter the reporting period – beginning date or the beginning date of the cost report period (e.g., 10/1/2010).

Reporting Period: End Date: Enter the reporting period – ending date or the ending date of the cost report period (e.g., 9/30/2011).

Part Year Cost Report: Enter an answer to the question "Is reporting period less than a full year?" This question identifies if the cost report is being prepared for a period that is not an entire fiscal year. If the cost report is for an entire fiscal year (October 1 – September 30), then enter No in the field. If the cost report is being prepared for a partial fiscal year, enter a response that explains the reason why (e.g., Supplemental Payment Request Approval was effective beginning on 7/1/20XX).

Cost Allocation Information

The purpose of this section is to obtain summary information regarding the cost allocation methodology the governmental entity utilized to allocate costs to various programs, grants, contracts and agreements.

Cost Allocation Plan: Enter either Yes or No indicating whether your agency has an approved Cost Allocation Plan (CAP). If the answer is yes, enter the name of the Cognizant Agency that approved the agency CAP in accordance with 45 CFR part 75.

Approved Indirect Cost Rate: Enter either Yes or No indicating whether your agency has an approved Indirect Cost Rate.

Indirect Cost Rate: Enter either Yes or No indicating whether your agency will be utilizing an Indirect Cost Rate. If yes, enter the agency's approved Indirect Cost Rate.

Summary of Payments and Billed Charge Data (Applicable to Cost Report)

Total Uninsured Charity Charges: Enter the total customary/market/commercial charges for individuals that have been classified, meet the requirement and admitted to receive benefit of charity care for the applicable cost report period identified on the form. The ambulance charges for services entered should be for ambulance services approved as charity during the cost report period and must exclude all unfunded Medicaid and Medicare costs and does not include bad

debt, payment shortfall(s), insurance allowances, courtesy allowances, or discounts given to patients who do not meet the provider's charity care policy or financial assistance policy.

Direct Medical Uninsured Charity Charges: (if the amounts differ from the total charity): Enter the total Direct Medical Uninsured Charity Charges for services provided for the applicable cost report period identified on the form if that amount is different from the total charity charges. The ambulance charges for services entered should be for ambulance services approved as charity during the cost report period and must exclude all unfunded Medicaid and Medicare costs and does not include bad debt, payment shortfall(s), insurance allowances, courtesy allowances, or discounts given to patients who do not meet the provider's charity care policy or financial assistance policy.

Charity Reimbursements: Enter the reimbursements received associated with charity charges for the applicable cost report period identified on the form. The total reimbursements received associated with charity charges entered must only be for **dates of service** during the cost report period. In instances where recovery may be made after the cost report year, providers are required to inform HHSC of any uncompensated charity claims that are reimbursed after the cost report submission to determine necessary refund(s). Providers are obligated to make the necessary refunds as a result of recoveries and reimbursements.

Additional Cost Data: (for informational purposes only): In addition to the statistical information entered for cost reporting period, additional cost data is being requested.
Medicare Charges: Enter the total Medicare Charges for services provided for the applicable cost report period identified on the form. The ambulance Medicare costs for services entered should be for dates of service during the cost report period.

Other Third-Party Charges: Enter the total Other Third-Party coverage (Commercial Pay) costs for services provided for the applicable cost report period identified on the form. Third-Party charges should include all incidental charges covered by any outside sources not including indigent programs, Medicare and Medicaid charges. The ambulance "other" costs for services entered should be for dates of service during the cost report period.

Charges for Self-Pay, County/City Indigent Recipient Programs: Enter the amount of Self-Pay, County/City Indigent received by program as previously defined.

Exhibit 2: Direct Medical (Ambulance Services)

Exhibit 2 identifies and summarizes from other exhibits all ambulance services costs within the cost report. Much of the information contained within this exhibit is from either Exhibit 5 or Exhibit 6; however, there are unique items of cost that are identified in this exhibit. **Only allocable expenditures related to Charity Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program will be included for supplemental payment.** This exhibit sums the personnel expenses and adds additional costs to calculate the total cost of Medical and Uncompensated Care Services.

Direct cost methods must be used whenever reasonably possible. Direct costing means that allowable costs, direct or indirect, incurred for the benefit of, or directly attributable to, a specific business component must be directly charged to that particular business component.

For example, the payroll costs of a direct service employee who works across cost areas within one contracted program would be directly charged to each cost area of that program based upon that employee's continuous daily time sheets and the costs of a direct care employee who works across more than one service delivery area would also be directly charged to each service delivery area based upon that employee's continuous daily time sheets. Health insurance premiums, life insurance premiums, and other employee benefits are applied as direct costs.

Direct costs are defined in accordance with 45 CFR 75.413 and only include Dedicated Direct Services Cost Centers, i.e. Ambulance cost center, which are comprised of a distinctly identifiable department or unit whose costs are associated with providing direct medical services.

Indirect costs are defined in accordance with 45 CFR 75.414 and may include costs benefitting more than one cost objective, and not readily assignable to the cost objectives specifically benefitted Cost Centers which included cost for those cost centers that are not solely dedicated to one activity but may be allocated to multiple activities.

Governmental providers must use reasonable methods of allocation and must be consistent in their use of allocation methods for cost-reporting purposes across all program areas and business entities. The allocation method should be a reasonable reflection of the actual business operations. Allocation methods that do not reasonably reflect the actual business operations and resources expended toward each unique business entity are not acceptable. Allocated costs are adjusted if HHSC considers the allocation method to be unreasonable. The provider must submit a detailed summary of their cost allocation methodology, including a description of the components, the formula for calculating the percentage and any additional supporting documentation as required by HHSC. Supplemental schedules must also be attached to the cost report listing each employee, job title, total salary and benefits, the applicable allocation percentage and the allocation amount that will be included in the cost report. The amounts from the supplemental schedule allocated to the Medicaid and Uncompensated Care programs should match the amounts entered on Exhibit 6 Schedule B with additional detail entered on Exhibit 7, Schedule C. Any change in cost-reporting allocation methods from one year to the next must be fully disclosed by the contracted provider on its cost report.

Indirect Costs Rate

If an Indirect Cost Rate (IDCR) is utilized, that rate must be applied to all appropriate cost objectives specifically identified in the cost report. Indirect cost is calculated by multiplying the Modified Total Direct Costs by the provider's approved indirect cost rate. These indirect rates are developed by the state cognizant agency and are updated annually. The methodology used by the respective cognizant agency to develop the Indirect Cost Rate (IDCR) has been approved by the cognizant federal agency. Indirect costs are included in the claim as reallocated costs. The provider is responsible to ensure that costs included in the cost report not included in the indirect cost rate, and no costs will be accounted for more than once.

All indirect cost calculations developed to arrive at the total allowable costs must be included in Exhibit 7 of the cost report. All scenarios utilized to calculate the indirect cost must be fully explained as well. The provider must verify that no duplicative costs are included in line 2.33

"Other Cost" of Exhibit 2. IDCR costs will be disallowed if it is determined that the provider has already claimed those same IDCR costs. All documents that support the indirect cost rate calculation must be maintained by the approved governmental entity and must be made immediately available upon request by HHSC.

Identified reductions, from Exhibit 6, are subtracted to calculate the adjusted amount of Direct Medical Costs allowable as part of the cost report. The cost report identifies the portion of allowable costs that are related to charity care and the cost to charge ratio applicable for the cost report period. The ratio is applied to billed charges associated with charity care charges resulting in the total computable amount for ambulance services. This amount is then reduced by the amount of any reimbursement received for charity care. The resulting amount is then multiplied by the applicable federal medical assistance percentage (FMAP) to calculate the amount of settlement due to, or owed by (if negative) the provider.

Exhibit 2 is separated into the sections identifying:

- Personnel / Payroll Expenses. This section of the exhibit includes, in part, expenditures from Exhibit 6. If these costs are already claimed as indirect costs or through the cost allocation plan, such costs cannot be claimed again in this section.
- Other Operating Costs. This section of the exhibit includes, in part, expenditures from Exhibit 5. If these costs are already claimed as indirect costs or through the cost allocation plan, such costs cannot be claimed again in this section.
- Reductions to Allowable Costs. This section of the exhibit includes reductions to expenditures identified in Exhibit 6.
- Cost Settlement Calculation. This section applies the cost to charge ratio calculation methodology to arrive at the final settlement due to or from the provider.

DIRECTIONS TO COMPLETE EXHIBIT 2

Personnel / Payroll Expenses

This section of the exhibit includes all personnel related expenditures and hours for the job classifications identified

Hours: The number of hours for each of the job classifications identified in this exhibit and for which costs are identified in Exhibit 6. Hours for this exhibit represent total paid hours that are reported by the provider on their payroll report as those hours relate to direct medical services. Total paid hours include, but are not limited to:

- Regular wage hours
- Sick hours
- Vacation hours

Payroll Taxes/Unemployment Compensation: the amount of the following payroll expenses:

- State Unemployment Payroll Taxes

- Federal Unemployment Payroll Taxes
- Unemployment Compensation (Reimbursing Employer)

Other Costs

This section of the exhibit identifies other operating costs not related to the job classifications identified above. Within this section, Support Services or Other may include personnel-related expenditures not identified in the job classifications in the section above.

All costs identified in the section of the exhibit are supported by supplemental schedules to the cost report and will be supplied at the time of cost report submittal.

Supplies and Materials Costs: Enter the amount of supplies and materials expenditures incurred by the provider during the cost report period, and for both non-medical and medical costs enter the amounts that are directly attributed to direct medical services.

- Medical supplies
- Office supplies
- Maintenance supplies
- Medical materials

Equipment Costs: Enter the total amount of equipment expenditures incurred by the provider during the cost report period. Reporting the total non-medical equipment costs as indirect amounts, and medical costs that are used in the reporting period as direct amounts. Equipment expenditures include, but are not limited to, the following non-depreciable items. If these costs are already claimed as indirect costs or through the cost allocation plan, such costs cannot be claimed again in this section.

- Medical equipment
- Computers
- Radios
- Communications equipment

Support Services Costs: Enter the total amount of Support Services expenditures incurred by the provider during the cost report period and enter the amounts that are directly attributed to direct medical services. Support Services expenditures may include personnel and non-personnel expenditures depending on if the personnel expenditures are represented in the job classification categories identified in this exhibit and detailed in Exhibit 6. Support Services expenditures include, but are not limited to, the following:

- Information technology salaries, benefits, and operating expenditures
- Telecommunications personnel and operating expenditures

Other Costs: Enter the total amount of other expenditures incurred by the provider during the cost report period and enter the amounts that are directly attributed to direct medical services. Other expenditures may include personnel and non-personnel expenditures depending on if the personnel expenditures are represented in the job classification categories identified in this exhibit and detailed in Exhibit 6. Other expenditures include, but are not limited to, the following:

- Depreciation expense (Exhibit 5)
- Parent organization allocated costs (discretely identified from prepared cost allocation plan (CAP))
- Other unit personnel and operating expenditures not otherwise identified (Indirect Cost)

Cost Settlement Calculation

Total Allowable Costs for Period of Service: The Total Allowable Costs entered into the cost report less any "other federal funding" received (No entry is required).

Total Allowable Direct Medical Costs for Period of Service: The Total Allowable Direct Medical Costs entered into the cost report less any "other federal funding" received (No entry is required).

Total Billed Charges for Period of Service: The Total Billed Charges for the applicable period of service (No entry is required).

Total Direct Medical Charges for Period of Service: The Total Direct Medical Charges for the applicable period of service only input if total charges included include non-medical charges.

Cost to Charge Ratio (CCR): The result of dividing a provider's Total Allowable Costs for the reporting period by the providers Total Billed Charges for the same period. The CCR is carried out to six (6) decimal places. The CCR will be monitored and additional support and explanation will be required if exceeding 100%. (No entry is required).

Total Charges Associated with Charity Care less any associated payments: The Total Billed Charges Associated with Charity services for the period applicable to the cost report less any associated payments received (No entry is required).

Total Billed Direct Medical Charges Associated with Charity Care: The Total Billed Direct Medical Charges Associated with Charity services for the period applicable to the cost report. (No entry is required).

Uninsured Charity Care Cost: The total direct medical costs associated with the direct medical charges. This is the result of the calculation of Direct Medical Cost to Charge Ratio multiplied with the allowable uninsured charity charges within the reporting period (No entry is required).

Charity Care Reimbursement: The amount of reimbursement received for charity care provided to patients within the reporting period that are received from any payer that reduce the unpaid balance of the amount entered on **Total Uninsured Charity Charges.** Include all subrogated awards or offsets (enter 0 if none).

Equals Settlement amount: The total Charity Allowable Costs for the period of service applicable to the cost report. This calculation is equal to the **Settlement Amount** for the reporting period (No entry is required).

Federal Medical Assistance Participation Rate (FMAP): The FMAP rate for the appropriate federal fiscal year of the cost report.

Non-Federal share Funds Certification of Public Expenditures (CPE amount): The amount of charges converted to cost associated with direct medical charity costs. This amount is the state share.

Amount due to the Provider: The net amount of the settlement due to or from a provider after the FMAP rate is applied.

Exhibit 3 – Cost Report Certification

Certification of Costs included in the cost report. This form attests to and certifies the accuracy of the financial information contained within the cost report.

DIRECTIONS TO COMPLETE EXHIBIT 3

Most of the information in Exhibit 3 will be updated automatically with information from previous exhibits. This exhibit must be signed and included **UPON COMPLETION OF ALL OTHER EXHIBITS**.

Upon completion of all other exhibits in the cost report, please **print this exhibit, sign the exhibit, have the form notarized, scan the exhibit, and include the signed exhibit** when sending the electronic version of the cost report to HHSC. Please have the appropriate person within the provider read and sign the form.

Signature Authority/Certifying Signature

Certifier Name:	Enter the name of the person that will be certifying the costs identified in the cost report (e.g., Jane Doe).
Title:	Enter the title of signer, or the title of the person that will be certifying the costs identified in the cost report (e.g., Director).
Print:	Please print this exhibit and have the appropriate person identified above sign the certification form.
Date:	Enter the date that the appropriate person identified above signs the certification form (e.g., 1/1/2011).

Signature Authority Check Box: Check the appropriate box that corresponds to the title of the person signing this Exhibit.

Notary: Upon printing and signing this Exhibit, please have this form notarized by a Notary Public.

Exhibit 4 – Certification of Funds

Certification of Public Expenditure that allows the state to use the computable Medicaid expenditures as the non-federal match of expenditures to draw the federal portion of Medicaid funding as identified in the settlement. This form attests to and certifies the accuracy of the provided financial information and that t the report was prepared in accordance with State and Federal audit and cost principal standards and that the costs have not been claimed on any other cost report for federal reimbursement purposes. This exhibit also identifies the amount of local provider expenditure that is allowable for use as the state match.

DIRECTIONS TO COMPLETE EXHIBIT 4

Most of the information in Exhibit 4 will be updated automatically with information from previous exhibits. This exhibit must be signed and included **UPON COMPLETION OF ALL OTHER EXHIBITS**.

Upon completion of all other exhibits in the cost report, please **print this exhibit, sign the exhibit, have the form notarized, scan the exhibit, and include the signed exhibit** when sending the electronic version of the cost report to HHSC. Please have the appropriate person within the provider read and sign the form.

Signature Authority/Certifying Signature

Print	Please print this exhibit and have the appropriate person sign the certification form.
Date:	Enter the date that the appropriate person identified above signs the certification form (e.g., 1/1/2011).
Certifier Name:	Enter the name of signer, or the person that will be certifying the public expenditures identified in the cost report (e.g., Jane Doe).
Title:	Enter the title of signer, or the title of the person that will be certifying the public expenditures identified in the cost report (e.g., Director).
Certifier Check Box	Check the appropriate box that corresponds to the title of the person signing this exhibit. If Other Agent/Representative is selected, please include the appropriate title in Column N, Line 40.
Notarized	Upon printing and signing this exhibit, please have this form notarized by a Notary Public.

Exhibit 5 – Schedule A (Depreciation Schedule)

Depreciation is only available to the assets in Direct Medical provision. Other assets of non-medical entities are not depreciable in consideration of this program. The depreciation schedule

identifies allowable depreciation expenses incurred by the provider related to. This exhibit will identify depreciable assets for which there was a depreciation expense during the cost report period. Information on this exhibit must come from a depreciation schedule maintained by the provider in accordance with appropriate accounting guidelines established by the provider and/or the parent organization of the provider. For depreciation expenses, the straight-line method should be used. Prior Period Accumulated Depreciation plus Depreciation for Reporting Period cannot exceed the total cost of an asset. In addition, assets that have been fully expensed should not be reported. If the asset or portion thereof has been funded by a separate federal agency, that amount must be reduce from the basis of the asset. If these costs are already claimed or through the cost allocation plan, such costs cannot be claimed again in this section.

Assets that serve more than one cost unit must be allocated by cost unit in accordance with 45 CFR 75.405(d) which states that if a cost benefits two or more projects or activities in proportions that can be determined without undue effort or cost, the cost must be allocated to the projects based on the proportional benefit. If a cost benefits two or more projects or activities in proportions that cannot be determined because of the interrelationship of the work involved, then, notwithstanding 45 CFR 75.405(c), the costs may be allocated or transferred to benefitted projects on any reasonable documented basis. Where the purchase of equipment or other capital asset is specifically authorized under a Federal award, the costs are assignable to the Federal award regardless of the use that may be made of the equipment or other capital asset involved when no longer needed for the purpose for which it was originally required.

DIRECTIONS TO COMPLETE EXHIBIT 5

Vehicles. Allowable vehicles are defined to include only vehicles that are used to provide Medicaid services. For depreciation expense related to vehicles, the provider must follow depreciable asset thresholds already in place at the provider and/or parent organization. The vehicle depreciation expense as reported on the cost report must come from the provider's depreciation schedule.

Asset Description:	Enter the description of the asset that will be included in this depreciation schedule. The name or account code, or both will suffice. If there is the need to add additional lines, please do so.
Month/Year Placed in Service:	Enter the month/year placed in service as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This is the month and the year that the depreciable asset was first put into service.
Years Useful Life:	Enter the number of years of useful life of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).
Cost:	Enter the amount of initial cost of the asset as identified on the provider's depreciation schedule.

Prior Period Accumulated Depreciation: Enter the amount of Prior Period Accumulated

Depreciation related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expenses to date related to the depreciable asset.

Depreciation for Reporting Period: Enter the amount of current period depreciation expense in the Depreciation for Reporting Period field related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expense incurred during the cost report period.

Direct Medical Allocation Statistic: Enter the allocation of ambulance services that the asset is used for direct medical services.

Equipment. For depreciation expense related to equipment, the provider must follow depreciable asset thresholds already in place at the provider and/or parent organization. The equipment depreciation expense as reported on the cost report must come from the provider's depreciation schedule.

Asset Description: Enter the description of the asset that will be included in this depreciation schedule. The name or account code, or both will suffice. If there is the need to add additional lines, please do so.

Month/Year Placed in Service: Enter the month/year placed in service as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This is the month and the year that the depreciable asset was first put into service.

Years Useful Life: Enter the number of years of useful life of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost: Enter the amount of initial cost of the asset as identified on the provider's depreciation schedule.

Prior Period Accumulated Depreciation: Enter the amount of Prior Period Accumulated Depreciation related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expenses to date related to the depreciable asset.

Depreciation for Reporting Period: Enter the amount of current period depreciation expense in the Depreciation for Reporting Period field related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expense incurred during the cost report period.

Direct Medical Allocation Statistic: Enter the allocation that the asset is used for direct medical

services.

Building. For depreciation expense related to buildings where the provider's vehicles or staff are housed with other agencies or entities, ONLY the portion related to the provider may be reported. If this is the case, the provider must attach a supplemental exhibit showing how the portion of the building related to the provider was calculated.

Asset Description: Enter the description of the asset that will be included in this depreciation schedule. The name or account code, or both will suffice. If there is the need to add additional lines, please do so.

Month/Year Placed in Service: Enter the month/year placed in service as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This is the month and the year that the depreciable asset was first put into service.

Years of Useful Life: Enter the number of years of useful life of the asset as identified on the provider's depreciation schedule that does not exceed Internal Revenue Service requirements (e.g., 20 for twenty years of useful life).

Cost: Enter the amount of initial cost of the asset as identified on the provider's depreciation schedule.

Prior Period Accumulated Depreciation: Enter the amount of Prior Period Accumulated Depreciation related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expenses to date related to the depreciable asset.

Depreciation for Reporting Period: Enter the amount of current period depreciation expense in the Depreciation for Reporting Period field related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expense incurred during the cost report period.

Ambulance Allocation Statistic: Enter the allocation that the asset is used for ambulance services.

Direct Medical Allocation Statistic: Enter the allocation that the asset is used for direct medical services.

Exhibit 6 – Worksheet B (Payroll and Benefits)

This exhibit includes the salary and benefits, and appropriate reductions related to contracted and employed staff of the provider. For this exhibit, all employed and contracted staff related to the provision of direct medical ambulance EMS services should be identified here. If these costs are already claimed as indirect costs or through the cost allocation plan, such costs cannot be claimed again in this section.

Attachment H
UC Payment Protocol

This exhibit includes several pre-populated staffing classifications for which information will need to be completed. The pre-populated staffing classifications include:

For Direct Costs in the provision of Direct Medical Services:

- **Paramedics:** This cost classification includes all personnel salary and benefit expenditures related to performing basic and advanced medical rescue procedures to access, stabilize, evacuate, and transport a patient to an appropriate medical facility's emergency department, including, but not limited to:
  - Paramedics
  - EMTs
  - …

- **CPR Technicians:** This cost classification includes all personnel salary and benefit expenditures related to the coordination of all EMS activities related to community education of CPR and First Aid skills and techniques, including, but not limited to:
  - CPR Techs
  -

- **Contracted EMT/Paramedics:** This cost classification includes all contracted expenditures related to performing basic and advanced medical rescue procedures to access, stabilize, evacuate, and transport a patient to an appropriate medical facility's emergency department, including, but not limited to:
  - Contracted Paramedics
  - Contracted EMTs
  - …

For Indirect Costs that support the provision of Direct Medical Services:

- **9-1-1 Call Technicians:** This cost classification includes all personnel salary and benefit expenditures related to operation of emergency communications equipment used in receiving, sending, and relaying medical self-help in response to emergency calls, including, but not limited to:
  - 9-1-1 Call Technicians
  - 9-1-1 Call Technician Assistants
  - …
- **Training Coordinators:** This cost classification includes all personnel salary and benefit expenditures related to providing training, quality, operational, and support of specific ambulance service training and organizational programs, including local pre-paramedic institutions, internal paramedic/communications medic instruction, training activities within Field Operations and Communications, and analysis of performance and quality improvement programs, including, but not limited to:
  - Training Coordinators
  - …

- **Quality Assurance Technicians:** Quality Assurance Technicians have the same job

description as training coordinators above. This cost classification includes all personnel salary and benefit expenditures related to providing training, quality, operational, and support of specific ambulance service training and organizational programs, including local pre-paramedic institutions, internal paramedic/communications medic instruction, training activities within Field Operations and Communications, and analysis of performance and quality improvement programs, including, but not limited to:

- Quality Assurance Techs
- …

- **Safety Officer:** This cost classification includes all personnel salary and benefit expenditures related to developing, administering, implementing, and evaluating departmental occupational safety program and activities, including, but not limited to:
  - Safety Officer
  - Safety office assistant
  - …

- **Billing / Account Representatives:** This cost classification includes all personnel salary and benefit expenditures related to verification of patients' insurance coverage, including Medicaid, collection of third-party insurance submissions and payments, and patient customer service-related tasks, including, but not limited to:
  - Billing representative
  - Account representative
  - Patient account representative
  - …

- **Medical Director:** This cost classification includes all personnel salary and benefit expenditures related to the clinical oversight of pre-hospital treatment rendered by EMS personnel. The Medical Director costs shall only include those costs as identified to be related to including, but not limited to:
  - Medical Director
  - Medical Director Assistant
  - …

- **Director:** This cost classification includes all personnel salary and benefit expenditures related to developing, administration, and overall operational effectiveness of the organization including strategic planning, leadership, and oversight of all operational aspects of the EMS Department, including, but not limited to:
  - Director
  - Director's Assistant
  - …

- **Public Information Officer:** This cost classification includes all personnel salary and benefit expenditures related to planning and directing public information, public

relations, media relations, or public involvement programs and developing, maintaining, and improving public awareness initiatives, including, but not limited to:

- Public Information Officer
- PIO Assistant
- …

DIRECTIONS TO COMPLETE EXHIBIT 6

Employee Information

This section of the exhibit is designed to identify employee information for the specific job classifications identified above. This section of the exhibit is also designed to discretely identify the employee information for any individual employee/contractor that must have a portion of their salary and/or benefits reduced from allowable expenditures on the cost report.

For each of the job classifications identified above, the following information must be included:

Employee #: Enter the Employee # for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Last Name: Enter the last name of the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

First Name: Enter the first name of the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Job Title/ Credentials: Enter the job title / credentials of the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Employee (E) /Contractor (C): Enter the appropriate designation, **either an E or a C,** of the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. E designates an employee of EMS. C designates a contractor for EMS.

Payroll and Benefits

This section of the exhibit is designed to identify payroll and benefit expenditures for the specific job classifications identified above. This section of the exhibit is also designed to discretely identify the payroll and benefit expenditures for any individual employee/contractor that must have a portion of their salary and/or benefits reduced from allowable expenditures on the cost report.

For each of the job classifications identified above, the following information must be included:

Gross Salary: Enter the gross salary amount for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Contractor Payments: Enter the amount of contractor payments for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Employee Benefits: Enter the amount of employee benefits for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. This includes all benefits that are not discretely identified in Columns J-L of this exhibit.

Employer Retirement: Enter the amount of employer retirement expenditure for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

FICA: Enter the amount of FICA expenditure for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Payroll Taxes: Enter the amount of payroll taxes expenditure for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Federal Funding Reductions

This section of the exhibit is designed to identify the federal funding, or other payroll and benefit expenditure reduction necessary for the specific job classifications identified above. This section of the exhibit is designed to discretely identify the payroll and benefit expenditures for any individual employee/contractor that must have a portion of their salary and/or benefits reduced from allowable expenditures on the cost report.

For each of the job classifications identified above, the following information must be included:

Allocated Funded Positions Entry: Enter the appropriate designation, either a Y or an N, for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. A "Y" in this field designates an employee for which a portion, or all of their salary and benefit expenditures are funded by federal funds or grants. An "N" in this field designates an employee for which a portion, or all of their salary and benefit expenditures are not funded by federal funds or grants, but still need to be removed from allowable expenditures as reported on the cost report.

Federal Funding: If the answer to the field previously is "Y", then enter the amount of federal funding related to the employee's salary and benefits that must be reduced from the total allowable costs as reported on the cost report.

Other Funds: Enter the amount of Other Amount to be Removed related to the employee's salary and benefits that must be reduced from the total allowable costs as reported on the cost report.

Payroll and Benefits Entry: Enter the amount of salary and appropriate benefits for all other personnel and staff related to the job classifications identified above, for which no salary or benefit expenditures must be reduced from the total allowable costs.

Exhibit 7-Schedule C – Cost Allocation Methodologies

This exhibit details the cost allocation methodologies employed by the governmental entity.

a. If you entered "yes" on Exhibit 1, Line 1.06, please provide a copy of your agency's approved Cost Allocation Plan (CAP).
b. If you entered "yes" on Exhibit 1, Lines 1.08 and 1.09, please provide a copy of your agency's approved Indirect Cost Rate (IDCR).
c. Provide a list of personnel cost worksheets that support your CAP or IDCR

Part 5: Methodology for Ensuring Payments are based on Uncompensated Charity Costs

STC 33 requires that the methodology used by the state to determine UC payments will ensure that payments are distributed based on uncompensated cost, unrelated to the source of the non-federal share. Eligible uncompensated costs must be for services provided to uninsured individuals who meet the provider's charity-care policy or financial assistance policy where all or a portion of the services are free of charge and where the provider's charity-care policy adheres to the charity-care principles of the Healthcare Financial Management Association (HFMA). This Part 5 describes the methodology used by the state to fulfill this requirement.

Each provider that qualifies for a payment from the UC Pool will be reimbursed a percentage of its total eligible uncompensated charity-care costs calculated as described in this Attachment H.

Providers may be categorized in four groups: hospitals, physician practice groups, government dental providers, and government ambulance providers. Within the hospital group, providers may be further subdivided based on existing classifications that have been approved by CMS for payments under Texas State Plan or 1115 waiver programs, or by directed payment models.