



2019 Accountability Report Instructions for ICF/IDD

*Intermediate Care Facilities for Individuals with an Intellectual Disability or Related
Conditions*

For assistance with:

Report completion

Rate Analysis Customer Information Center
(512) 424-6637 or RAD-LTSS@hhsc.state.tx.us

Receipt of the report

Phone: (512) 438-2680, Email: costinformation@hhsc.state.tx.us

Report Groups assigned to provider's entity

Phone: (512) 438-2680, Email: costinformation@hhsc.state.tx.us

Report Preparers or the list of trained Preparers

Phone: (512) 438-2680, Email: costinformation@hhsc.state.tx.us

Adding Contacts or issues with your State of Texas Automated Information Reporting System (STAIRS) Login:

Fairbanks, LLC. Phone: (877) 354-3831, Email: info@fairbanksllc.com

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State of Texas Automated Information System (STAIRS)

STAIRS is the web-based system for long-term care Medicaid cost reporting in the State of Texas. The system is in use for all long-term services and supports programs that are required to submit cost reports: the 24-hour Residential Child Care (24RCC) program; the Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID) program; the Home and Community-based Services (HCS) and Texas Home Living (TxHmL) waiver programs; the Nursing Facilities (NF), Primary Home Care (PHC) and Community Living Assistance and Support Services (CLASS) programs (including both CLASS Case Management Agency (CLASS CMA) and Class Direct Service Agency (CLASS DSA) providers) via the CPC (CLASS/PHC) Cost Report; the Day Activity and Health Services (DAHS) program; and the Residential Care (RC) program.

Login IDs and passwords do not change year-to-year. The provider's designated Primary Entity Contact can access STAIRS via the links given in the email notifying them of their login ID and password. If the provider is new for 2018, the provider's Primary Entity Contact should receive an e-mail with their login information. If the provider's Primary Entity Contact has not received an e-mail with their login information, they should contact costinformation@hhsc.state.tx.us. Preparers can only access STAIRS if they have been designated as the Preparer by the Primary Entity Contact and have received an e-mail notifying them of their login ID and password for STAIRS.

Cost Report Training

All Texas Health and Human Services Commission (HHSC) sponsored cost report training will be offered via webinar. There will still be separate webinars for new preparers and for those who have taken cost report training in previous years for each program. Each webinar will include both the general and program-specific content for a program.

Upon completion of the appropriate webinar, preparers will be given the appropriate credit to be qualified to submit a cost report. Attendees of a Cost Report Training webinar will not receive a certificate as HHSC Rate Analysis will track training attendance internally. Additionally, there will be NO Continuing Education Units (CEUs) or Continuing Professional Education (CPEs) credits for completing a cost report training webinar.

In order to be able to submit a 2018 accountability report, a preparer must attend the 2017 or 2018 Cost Report Training Webinar. Preparers without the proper training credit will not be able to access the STAIRS data entry application.

Purpose of an Accountability Report

The purpose of a Medicaid Accountability Report is to gather financial and statistical information for HHSC to use in developing reimbursement rates. Some cost reports are also used in the determination of accountability under the Attendant Compensation Rate Enhancement program.

Who Must Complete this Report?

Accountability Reports are only required when requested by the HHSC Rate Analysis. Any HCS provider that is enrolled in Attendant Compensation Rate Enhancement as described in 355.112(h)(2) and receives a request to submit an Accountability Report is required to complete and submit a HCS Accountability Report. The only exception to this requirement is if the provider did not provide any billable attendant services to HHSC recipients during the requested reporting period.

General

This accountability report is governed by the following rules and instructions.

- Cost Determination Process rules at 1 TAC §§355.101-355.110;
- Attendant Compensation Rate Enhancement rules at 1 TAC §355.112;
- The Texas HCS/TxHmL Program-Specific Rules at 1 TAC §355.722;
- The *Instructions* for completion of the report;
- The 2018 general and program-specific Cost Report training materials.

As stated at 1 TAC §355.105(b)(1), federal tax laws and Internal Revenue Service (IRS) regulations do not necessarily apply in the preparation of Texas Medicaid Cost Reports. Except as otherwise specified in HHSC's Cost Determination Process Rules, cost reports should be prepared consistent with generally accepted accounting principles (GAAP). Where the Cost Determination Process Rules and/or program-specific rules conflict with IRS, GAAP or other authorities, the Cost Determination Process Rules and program-specific rules take precedence.

In order to properly complete this accountability report, the preparer must:

- Read these instructions;
- Review the provider's most recently audited cost report and audit adjustment information, if applicable. The most recently received adjustments are likely those for the 2017 Cost Report (if adjustment information has not been received, call (512) 438-2680);
- Have attended a Cost Report Training webinar session and received credit for the 2018 Cost Report Training sponsored by HHSC Rate Analysis. Preparers without the proper training credit will not be able to access the STAIRS data entry application;
- Create a comprehensive reconciliation worksheet to serve as a crosswalk between the facility/contracted provider's accounting records and the accountability report; and
- Create worksheets to explain adjustments to year-end balances due to the application of Medicaid accountability reporting rules and instructions.

Due Date and Submission

This report is due at HHSC RAD as specified in the HHSC RAD letter requesting the AR.

All attachments and signed and notarized certification pages must be uploaded into STAIRS.

Reports will not be considered “received” until the online report has been finalized and all required supporting documents uploaded. See *Appendix A. Uploading Documents into STAIRS*. Documentation mailed rather than uploaded into the system will not be accepted.

1 TAC §355.105(c)

Reporting Period

The reporting period is any period of time between January 1, 2018 and December 31, 2018, during which the provider was a participant in the rate enhancement. The reporting period must not exceed twelve months. The beginning and ending dates are pre-populated. If provider believes the pre-populated dates are incorrect, it is extremely important to call (512) 438-2680 before continuing with cost report preparation. Refer to the *Instructions*, **Step 2** for additional assistance.

Website

The HHSC Rate Analysis website contains program specific cost report instructions, cost report training information and materials, and payment rates. Additional information and features are added periodically. We encourage you to visit our website at the following link: <https://rad.hhs.texas.gov/long-term-services-supports>

Failure to File an Acceptable Accountability Report

According to 1 TAC §355.112(h)(4), failure to submit a timely Accountability Report, completed in accordance with instructions and rules, by the report due date may result in vendor hold.

Extensions Granted Only for Good Cause

Extensions of accountability report due dates are limited to those requested for good cause. Good cause refers to extreme circumstances that are beyond the control of the contracted provider and for which adequate advance planning and organization would not have been of any assistance. HHSC Rate Analysis must receive requests for extensions prior to the due date of the cost report. The extension request must be made by the provider (owner or authorized signor). The extension request must clearly explain the necessity for the extension and specify the extension due date being requested. Failure to file an acceptable cost report by the original accountability report due date because of the denial of a due date extension request constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111.

TAC §355.105(c)(3)

Standards for an Acceptable Accountability Report

To be acceptable, an accountability report must:

1. Be completed in accordance with the Cost Determination Process Rules, program-specific rules, accountability report instructions, and policy clarifications;
2. Be completed for the correct cost-reporting period (Note that the accountability reporting period has been prepopulated. See **Step 4**. If provider believes that the

dates are incorrect, contact HHSC Rate Analysis at costinformation@hhsc.state.tx.us for assistance);

3. Be completed using an accrual method of accounting (except for governmental entities required to operate on a cash basis);
4. Be submitted online as a 2018 Accountability Report for the correct program through STAIRS;
5. Include any necessary supporting documentation, as required, uploaded into STAIRS;
6. Include signed, notarized, original certification pages (Accountability Certification and Methodology Certification) scanned and uploaded into STAIRS
7. Calculate all allocation percentages to at least two decimal places (i.e., 25.75%);
8. If allocated costs are reported, include acceptable allocation summaries, uploaded into STAIRS.

Return of Unacceptable Accountability Reports

Failure to complete accountability reports according to instructions and rules constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111. Accountability reports that are not completed in accordance with applicable rules and instructions will be returned for correction and resubmission. The return of the accountability report will consist of un-certifying the file originally submitted via STAIRS which will re-open the accountability report to allow additional work and resubmission by the contracted provider. Notification of the return will be sent through e-mail and certified mail. HHSC grants the provider a compliance period of no more than 15 calendar days to correct the contract violation. Failure to resubmit an **acceptable** corrected accountability report by the due date indicated in the return notification will result in recommendation of a vendor hold.

1 TAC §355.106(a)(2)

Amended Accountability Reports

Provider-initiated amended accountability reports must be received no more than 60 calendar days after the original accountability report due date. Amended accountability report information that cannot be verified at least 30 calendar days prior to the public hearing on proposed payment rates for the program will not be used in the determination of payment rates.

If, at any time, a provider becomes aware of an error on their accountability report, the provider must contact the Rate Analysis Customer Information Center to determine if an amended accountability report is required.

1 TAC §355.105(d)

Accounting Methods

All revenues, expenses, and statistical information submitted on accountability reports must be based upon an accrual method of accounting except where otherwise specified in the Cost Determination Process Rules or program-specific reimbursement methodology rules. Governmental entities may report on a cash basis or modified accrual basis. To be allowable on the accountability report, costs must have been accrued during the cost reporting period, and paid within 180 days of the end of the cost reporting period unless the provider is under bankruptcy protection and has received a written waiver of the 180-day rule from HHSC Rate Analysis.

1 TAC §355.105(b)(1)

Accountability Report Certification

Contracted providers must certify the accuracy of the accountability report submitted to HHSC. Contracted providers may be liable for civil and/or criminal penalties if the accountability report is not completed according to HHSC requirements or if the information is misrepresented and/or falsified. Before signing the certification pages, carefully read the certification statements to ensure that the signers have complied with the accountability-reporting requirements. The Methodology Certification page advises preparers that they may lose the authority to prepare future accountability reports if accountability reports are not prepared in accordance with all applicable rules, instructions, and training materials.

Reporting Data/Statistics

Statistical data such as "Hours" must be reported to two decimal places. Please note that the two decimal places are NOT the same as the minutes, but are stated as the percent of an hour. For example, when reporting the hours for Registered Nurses (RN), 150 hours and 30 minutes would be reported as 150.50 hours and 150 hours and 20 minutes would be reported as 150.33 hours.

Direct Costing

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

Split Payroll Periods

If a payroll period is split such that part of the payroll period falls within the accountability reporting period and part of the payroll period does not fall within the accountability reporting period, the provider has the option of direct costing or allocating the hours and salaries associated with the split payroll period.

For example, if the payroll period covered two weeks, with 6 days included in the accountability-reporting period and 8 days not included in the accountability-reporting period, the provider could either review their payroll information to properly direct cost the paid hours and salaries for only the 6 days included in the accountability-reporting period or the provider could allocate 6/14th of the payroll period's hours and salaries to the accountability report. The method chosen must be consistently applied each accountability-reporting period. Any change in the method of allocation used from one reporting period to the next must be fully disclosed as per 1 TAC §355.102(j)(1)(D).

Cost Allocation Methods

Whenever direct costing of shared costs is not reasonable, it is necessary to allocate these costs either individually or as a pool of costs across those business components sharing in the benefits of the shared costs. The allocation method must be a reasonable reflection of the actual business operations of the provider. Contracted providers must use reasonable and acceptable methods of allocation and must be consistent in their use of allocation methods for cost-reporting purposes across all program areas and business components. Allocated costs are adjusted during the audit verification process if the allocation method is unreasonable, is not one of the acceptable methods enumerated in the Cost Determination Process Rules, or has not been approved in writing by HHSC Rate Analysis. An indirect allocation method approved by some other department, program, or governmental entity (including Medicare, other federal funding source or state agency) is not automatically approved by HHSC for cost-reporting purposes. See **Appendix B** for details on the types of approved allocation methodologies, when each can be used and when, and how to contact HHSC for approval to use an alternate method of allocation other than those approved.

If there is more than one business component, service delivery program, or Medicaid program within the entire related organization, the provider is considered to have central office functions, meaning that administration functions are more than likely shared across various business components, service delivery programs, or Medicaid contracts. Shared administration costs require allocation prior to being reported as central office costs on the cost report. The allocation method(s) used must be disclosed as the allocated costs are entered into STAIRS and an allocation summary must be prepared and uploaded to support each allocation calculation.

An adequate allocation summary must include for each allocation calculation: a description of the numerator and denominator that is clear and understandable in words and in numbers, the resulting percentage to at least two decimal places, a listing of the various cost categories to be allocated, 100% of the provider's expenses by cost category, the application of the allocation percentage to each shared cost, the resulting allocated amount, and the cost report item on which each allocated amount is reported. The description of the numerator and denominator should document the various cost components of each.

For example, the "salaries" allocation method includes salaries/wages and contracted labor (excluding consultants). Therefore, the description of the numerator and the denominator needs to document that both salaries/wages and contracted labor costs were included in the allocation calculations. For the "labor cost" allocation method, the cost report preparer needs to provide documentation that salaries/wages, payroll taxes, employee benefits, workers' compensation costs, and contracted labor (excluding consultants) were included in the allocation calculations. For the "cost-to-cost" allocation method, the cost report preparer needs to provide documentation that all allowable facility and operating costs were included in the allocation calculations. For the "total-cost-less-facility-cost" allocation method, the cost report preparer needs to provide documentation that all facility costs were excluded.

Any allocation method used for cost-reporting purposes must be consistently applied across all contracted programs and business entities in which the contracted provider has an interest (i.e., the entire related organization). If the provider used different allocation methods for reporting to other funding agencies (e.g., USDA, Medicare, HUD), the cost report preparer must provide reconciliation worksheets to HHSC upon request. These reconciliation worksheets must show: 1) that costs have not been charged to more than one funding source; 2) how specific cost categories have been reported differently to each funding source and the reason(s) for such reporting differences; and 3) that the total amount of costs (allowable and unallowable) used for reporting is the same for each report.

Any change in allocation methods for the current year from that used in the previous year must be disclosed on the cost report and accompanied by a written explanation of the reasons for the change. Allocation methods based upon revenue or revenue streams are not acceptable.

A provider may have many costs shared between business components. For example, a RC provider that also provides Medicare Home Health, Medicaid Home Health, private pay services and operates a durable medical equipment company might have shared attendant staff, shared nursing staff, shared clerical staff, shared administration costs, and other shared costs. Guidelines for allocation of various expenses will be provided in each Step of the *Specific Instructions* as appropriate.

1 TAC §355.102(j) and §355.105(b)(2)(B)(v)

Recordkeeping

Providers must maintain records that are accurate and sufficiently detailed to support the legal, financial, and statistical information contained in the accountability report. These records must demonstrate the necessity, reasonableness, and relationship of the costs to the provision of resident care, or the relationship of the central office to the individual provider. These records include, but are not limited to, accounting ledgers, journals, invoices, purchase orders, vouchers, canceled checks, timecards, payrolls, mileage and flight logs, loan documents, insurance policies, asset records, inventory records, organization charts, time studies, functional job descriptions, work papers used in the preparation of the accountability report, trial balances, cost allocation spreadsheets, and minutes of meetings of the board of directors. Adequate documentation for seminars/conferences includes a program brochure describing the seminar or a conference program with a description of the workshop attended. The documentation must provide a description clearly demonstrating that the seminar or workshop provided training pertaining to contracted-care-related services or quality assurance.

1 TAC §355.105(b)(2)(A) and §355.105(b)(2)(B)

Recordkeeping for Owners and Related Parties

Regarding compensation of owners and related parties, providers must maintain the following documentation, at a minimum, for each owner or related party:

- A detailed written description of actual duties, functions, and responsibilities;
- Documentation substantiating that the services performed are not duplicative of services performed by other employees;

- Timesheets or other documentation verifying the hours and days worked; (*NOTE: this does not mean number of hours, but actual hours of the day*);
- The amount of total compensation paid for these duties, with a breakdown of regular salary, overtime, bonuses, benefits, and other payments;
- Documentation of regular, periodic payments and/or accruals of the compensation;
- Documentation that the compensation was subject to payroll or self-employment taxes; and
- A detailed allocation worksheet indicating how the total compensation was allocated across business components receiving the benefit of these duties.

1 TAC §355.105(b)(2)(B)(xi)

Retention of Records

Each provider must maintain records according to the requirements stated in 40 TAC §69.158 (relating to how long contractors, subrecipients, and subcontractors must keep contract-related records).

- The rule states that records must be kept for a minimum of three years and 90 days after the end of the contract period.
- If any litigation, claim, or audit involving these records begins before three years and 90 days expire, the contractor, subrecipient, or subcontractor must keep the records and documents for not less than three years and 90 days or until all litigation, claims, or audit findings are resolved, whichever is longer.

If a contractor is terminating business operations, the contractor must ensure that:

- Records are stored and accessible; and
- Someone is responsible for adequately maintaining the records.

1 TAC §355.105(b)(2)(A)

Failure to Maintain Records

Failure to maintain all work papers and any other records that support the information submitted on the accountability report relating to all revenue, expense, allocations and statistical information constitutes an administrative contract violation. Procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title (relating to Administrative Contract Violations).

1 TAC §355.105(b)(2)(A)(iv)

Access to Records

Each provider or its designated agent(s) must allow access to all records necessary to verify information submitted on the accountability report. This requirement includes records pertaining to related-party transactions and other business activities in which the contracted provider is engaged. Failure to allow access to any and all records necessary to verify information submitted to HHSC on accountability reports constitutes an administrative contract violation.

1 TAC §355.106(f)(2) and 1 TAC §355.452(m)

Field Audits and Desk Reviews of Accountability Reports

Each Medicaid accountability report is subject to either a field audit or a desk review by HHSC Cost Report Review Unit (CRRU) Audit staff to ensure the fiscal integrity of the program. Accountability report audits are performed in a manner consistent with generally accepted auditing standards (GAAS), which are included in Government Auditing Standards: Standards for Audit of Governmental Organizations, Programs, Activities, and Functions. These standards are approved by the American Institute of Certified Public Accountants and are issued by the Comptroller General of the United States.

During the course of a field audit or a desk review, the provider must furnish any reasonable documentation requested by HHSC auditors within ten (10) working days of the request or a later date as specified by the auditors. If the provider does not present the requested material within the specified time, the audit or desk review is closed, and HHSC automatically disallows the costs in question, pursuant to 1 TAC §355.105(b)(2)(B)(xviii).

1 TAC §355.105(f) and §355.106

For desk reviews and field audits where the relevant records are located outside the state of Texas, the provider's financial records must be made available to HHSC's auditors within fifteen (15) working days of field audit or desk review notification. Whenever possible, the provider's records should be made available within Texas. When records are not available within Texas, the provider must pay the actual costs for HHSC staff to travel to and review the records located out of state. HHSC must be reimbursed for these costs within 60 days of the request for payment in accordance with 1 TAC §355.105(f).

Notification of Exclusions and Adjustments

HHSC notifies the provider by e-mail of any exclusions and/or adjustments to items on the accountability report. See **Step 12** and **Step 13**. Cost Report Review Unit (CRRU) furnishes providers with written reports of the results of field audits.

1 TAC §355.107

Informal Review of Exclusions and Adjustments

A provider who disagrees with HHSC's adjustments has a right to request an informal review of the adjustments. Requests for informal reviews must be received by HHSC Rate Analysis within 30 days of the date on the written notification of adjustments, must be signed by an individual legally responsible for the conduct of the interested party and must include a concise statement of the specific actions or determinations the provider disputes, the provider's recommended resolution, and any supporting documentation the provider deems relevant to the dispute. Failure to meet these requirements may result in the request for informal review being denied.

1 TAC §355.110

Definitions

Accrual Accounting Method - A method of accounting in which revenues are recorded in the period in which they are earned and expenses are recorded in the period in which they are incurred. If a facility operates on a cash basis, it will be necessary to convert from cash to accrual basis for cost-reporting purposes. Care must be taken to ensure that a proper cutoff of accounts receivable and accounts payable occurred both at the beginning and ending of the reporting period. Amounts earned although not actually received and amounts owed to employees and creditors but not paid should be included in the reporting period in which they were earned or incurred. Allowable expenses properly accrued during the cost-reporting period must be paid within 180 days after the fiscal year end in order to remain allowable costs for cost-reporting purposes, unless the provider is under bankruptcy protection and has obtained a written waiver from HHSC from the 180-day rule in accordance with 1 TAC §355.105(b)(1). If accrued expenses are not paid within 180 days after the fiscal year end and no written exception to the 180-day rule has been approved by HHSC, the cost is unallowable and should not be reported on the cost report. If the provider's cost report is submitted before 180 days after the provider's fiscal year end and the provider later determines that some of the accrued costs have not been paid within the required 180-day period, the cost report preparer should submit a revised cost report with the unpaid accrued costs removed.

1 TAC §355.105(b)(1)

Attendant Care for Community - An attendant is the unlicensed caregiver providing direct assistance to the consumers with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). An attendant also includes:

- A driver who is transporting consumers in the ICF/IID, DAHS, RC, and CBA AL/RC programs and the HCS Supervised Living/Residential Support Services (SL/RSS) and HCS and TxHmL Day Habilitation settings;
- Medication aides in the ICF/IID, RC and CBA AL/RC programs and HCS SL/RSS setting; and
- Direct care workers, direct care trainers and job coaches in the ICF/IID, HCS and TxHmL programs.

Attendants do not include the director, administrator, assistant director, assistant administrator, clerical and secretarial staff, professional staff, other administrative staff, licensed staff, attendant supervisors, cooks and kitchen staff, maintenance and groundskeeping staff, activity director, Qualified Mental Retardation Professionals (QIDPs), assistant QIDPs, direct care worker supervisors, direct care trainer supervisors, job coach supervisors, foster care providers, and laundry and housekeeping staff. See the TAC reference for additional details and exceptions.

1 TAC §355.112(b)

Common Ownership - Exists when an individual or individuals possess any ownership or equity in the contracted provider and the institution or organization serving the contracted provider. If a business entity provides goods or services to the provider and also has common ownership with the provider, the business transactions between the two

organizations are considered related-party transactions and must be properly disclosed. Administrative costs shared between entities that have common ownership must be properly allocated and reported as central office costs (i.e., shared administrative costs). See the definition for Related Party.

1 TAC §355.102(i)(1)

Component Code - Specific to IID programs, this is a three-digit code assigned by the HHSC CARE system that is specific to one contracted provider. It may cover one or multiple contracts held by that provider. This code is added to the end of a string that reads "0000H0xxx" for HCS and TxHmL and "0000I0xxx" for ICF/IID to identify the provider in certain HHSC Rate Analysis communications.

Contract Labor - Labor provided by non-staff individuals. Non-staff refers to personnel who provide services to the contracted provider intermittently, whose remuneration (i.e., fee or compensation) is not subject to employer payroll tax contributions (e.g., FICA/Medicare, FUTA, or SUTA) and who perform tasks routinely performed by employees. Contract labor does not include consultants. Contract labor hours must be associated with allowable contract labor costs as defined in 1 TAC §355.103(b)(2)(C).

Contracted Provider - The individual or legal business entity that is contractually responsible for providing Medicaid services, i.e., the business component with which Medicaid contracts for the provision of the services to be reported in this accountability report. See definitions for *Component Code* and *Contracting Entity*.

Contracting Entity - The business component with which Medicaid contracts for the provision of the Medicaid services included on this accountability report.

Control - Exists if an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. Control includes any kind of control, whether or not it is legally enforceable and however it is exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise. Organizations, whether proprietary or nonprofit, are considered to be related through control to their directors in common.

1 TAC §355.102(i)(1) and 1 TAC §355.102(i)(3)

Controlling Entity - The individual or organization that owns the contracting entity. Controlling entity does not refer to provider's contracted management organization.

Mileage Reimbursement - Reimbursement paid to the attendant for the use of his or her personal vehicle and which is not subject to payroll taxes.

Related - Related to a contracted provider means that the contracted provider to a significant extent is associated or affiliated with, has control of, or is controlled by the organization furnishing services, equipment, facilities, leases, or supplies. See the definitions of Common Ownership, Control and Related Party.

1 TAC §355.102(i)(1)

Related Party - A person or organization related to the contracted provider by blood/marriage, common ownership, or any association, which permits either entity to exert power or influence, either directly or indirectly, over the other. In determining whether a related-party relationship exists with the contracted provider, the tests of common ownership and control are applied separately. Control exists where an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. The existence of an immediate family relationship will create an irrefutable presumption of relatedness through control or attribution of ownership or equity interests where the significance tests are met. The following persons are considered immediate family for cost-reporting purposes: (1) husband and wife; (2) natural parent, child and sibling; (3) adopted child and adoptive parent; (4) stepparent, stepchild, stepsister, and stepbrother; (5) father-in-law, mother-in-law, brother-in-law, son-in-law, sister-in-law, and daughter-in-law; (6) grandparent and grandchild; (7) uncles and aunts by blood or marriage; (8) first cousins, and (9) nephews and nieces by blood or marriage. Disclosure of related-party information is required for all allowable costs reported by the contracted provider. See also definitions of *Common Ownership*, *Control*, *Related*, and *Related-Party Transactions*. See also the Cost Report Training materials.

1 TAC §355.102(i)

Related-Party Transactions - The purchase/lease of buildings, facilities, services, equipment, goods or supplies from the contracted provider's central office, an individual related to the provider by common ownership or control, or an organization related to the provider by common ownership or control. Allowable expenses in related-party transactions are reported on the cost report at the cost to the related party. However, such costs must not exceed the price of comparable services, equipment, facilities, or supplies that could be purchased/leased elsewhere in an arm's-length transaction.

1 TAC §355.102(i)

Workers' Compensation Costs - For cost-reporting purposes, the costs accrued for workers' compensation coverage (such as commercial insurance premiums and/or the medical bills paid on behalf of an injured employee) are allowable. Costs to administer a safety program for the reduction/prevention of employee injuries are not workers' compensation costs; rather, these costs should be reported as Administration Costs. See definition of *Safety Program*.

Detailed Instructions

General System Navigation

Add Record: Used to add lines to the current category. It may be used to add an initial entry to the category or to add Allocation detail to an initial entry. If more lines are needed than initially appear, enter the information for the initially appearing lines, Save, and click Add Record again for more lines.

Edit Record: Click the button beside the record to be edited before clicking this box. This will allow the user to change any specifics previously added to this record.

Delete Record: Click the button beside the record to be deleted before clicking this box. This will delete the selected record.

Save: Used to save the current data. Will save the information in the current location and allow additional Add, Edit or Delete actions.

Save and Return: Saves the current data and returns to the prior level screen.

Cancel: Cancels all unsaved information on the current screen and returns user to the prior level screen.

Stop Signs: A stop sign appears when an action needs to be taken by the preparer in order to either continue or before finalizing the cost report. They will variously tell the preparer that an action must be taken prior to being able to "Save" information in the current screen, that an edit must be responded to before the report can be finalized, or that a required piece of information is needed on the current screen.

User Interface and Dashboard

Entity List

Dashboard	Cost Reporting	Manage
---------------------------	--------------------------------	------------------------

[Reference Materials](#)

John Smith

[Edit My Info](#)

Director

123 Main St.
Austin, TX

Phone: 123456789

Your Roles

- 100014001 - ICF/IID

General Reference Material	Program Specific Reference Material
<ul style="list-style-type: none"><input checked="" type="checkbox"/> Helpful Information for Contacts and Preparers<input checked="" type="checkbox"/> How to Import Depreciable Assets Instructions<input checked="" type="checkbox"/> STAIRS - Managing Contacts - Procedures<input checked="" type="checkbox"/> Uploading File Instructions<input checked="" type="checkbox"/> 2015 STAIRS General Announcement	<ul style="list-style-type: none"><input type="checkbox"/> Program Specific Reference Materials

The initial screen a STAIRS user will see upon logging into the system is the Dashboard. From there the user can see and edit their personal contact information, to include e-mail, address and telephone and fax numbers. Also on this Dashboard page are important information messages and listings of important dates and upcoming training opportunities. Training registration can be accessed from this page.

By clicking on "Manage" to the right on the top bar, the user can, depending on his or her permissions, add a contact, attach a person to a role or assign a preparer.

The document titled "Managing Contacts Processing Procedures" gives detailed instructions for managing contacts, including understanding roles and what can be done within the system by persons assigned to the various roles. This document is located in the Reference Materials section located at the bottom of all STAIRS pages.

The Upload Center is also located under "Manage".

Once the user is in the system, they can click on "Cost Reporting" on the top bar. If the user has access permission for only a single component code and program, for example Component Code 8zz for HCS/TxHmL, then there will only be one option to click on the initial Cost Reporting page. If the user has access permission for more than one component code and/or program, for example Component Code 8zz for HCS/TxHmL and Component Code 8zy for HCS/TxHmL and ICF/IID, then the user will need to choose the component code and report in which the user wishes to work.

Combined Entity Data

Step 1. Combined Entity Identification

1. Combined Entity Identification

Combined Entity Identification

Phone:
Fax:
Street Address:
Mailing Address:
[✔ Edit Information](#)

Entity Contact Identification

Name:
Job Title:
Entity Name:
Email:
Phone:
Fax:
Mailing Address:
[✔ Edit Information](#)

Financial Contact

Name:
Job Title:
Entity Name:
Email:
Phone:
Fax:
Mailing Address:
[✔ Edit Information](#)

Report Preparer Identification

Name:
Job Title:
Entity Name:
Email:
Phone:
Fax:
Mailing Address:
[✔ Edit Information](#)

Location of Accounting Records that Support this Report

Primary Physical Address:
[✔ Edit Information](#)

Combined Entity Identification

In this section the provider may update telephone, e-mail and address information for the combined entity. If this is a single provider entity with no combined entities, this will be the information for the contracted provider as well.

Entity Contact Identification

In this section, the provider may update the information on the contact person. The contact person must be an employee of the controlling entity, parent company, sole member, governmental body, or related-party management company (i.e., the entire related organization) who is designated to be contacted concerning information reported on the cost report. The contact person should be able to answer questions about the contents of the provider's cost report.

Financial Contact

A primary contact may designate a Financial Contact. This person can review the cost report, but may not make entries into the system.

Report Preparer Identification

In accordance with 1 TAC §355.102(d), it is the responsibility of each provider to ensure that each accountability report preparer who signs the Accountability Report Certification completes the required HHSC-sponsored accountability report training. The STAIRS accountability reporting application will identify whether the person designated as a preparer has completed the required training. A list of preparers who have completed the training may be accessed through the Rate Analysis website (see the WEBSITE section of the General Instructions) by scrolling down to the "Training Information" heading and clicking on "Cost Reports", then "Mandatory Cost Report Training" and then "Preparer List."

Preparers must complete cost report training for every program for which an accountability report is submitted. Such training is required every other year for the odd-year cost report in order for the preparer to be qualified to complete both that odd-year cost report and the following even-year accountability report. To sign as preparer of a 2018 accountability report for a specific program, the preparer must have attended and received credit for the appropriate 2018 Cost Report.

Accountability report preparers may be employees of the provider or persons who have been contracted by the provider for the purpose of accountability report preparation. NO EXEMPTIONS from the cost report training requirements will be granted.

Location of Accounting Records that Support this Report

Enter the address where the provider's accounting records and supporting documentation used to prepare the cost report are maintained. This should be the address at which a field audit of these records can be conducted. These records do not refer solely to the work papers used by the provider's CPA or other outside cost report preparer. All working papers used in the preparation of the cost report must be maintained in accordance with 1 TAC 355.105(b)(2)(ii). (See also the Recordkeeping section of the General Instructions.)

Step 2. General Information

2. General Information

Combined Entity Report Period Beginning (mm/dd/yyyy) *	06/01/2018
Combined Entity Report Period Ending (mm/dd/yyyy) *	03/01/2019

Do you request to aggregate by program those contracts held by this Combined Entity which participated in the Rate Enhancement for the purpose of determining compliance with spending requirements? Indicate below by applicable program. If you only have one contract in a particular program or are only submitting one accountability report for a program select "No" for aggregation.

CLASS DSA	
DAHS	
DBMD	
HCS/TXHTML	
ICFRID *	Yes
NF	
PHC	
RC	

Save Save and Return Cancel

Combined Entity Reporting Period Beginning and Ending Dates

These dates represent the beginning and ending dates for the combined entity's reporting period. If this is a single provider entity with no combined entities, the information for the contracted provider will be used as that of the combined entity. For a combined entity that submitted a cost report in a prior year, these dates will be based on the dates from the prior cost report. For a combined entity that is reporting for the first time this year, the dates are based on the contract beginning date and the assumption that the provider is on a calendar fiscal year, so has an ending date of 12/31 of the cost report year. If these dates are not correct, contact HHSC Rate Analysis at costinformation@hhsc.state.tx.us for assistance. Failure to assure that the reporting period is correctly identified will result in the cost report being returned and all work previously done on the report being deleted from the system.

This reporting period for an Accountability Report will be specified by the Rate Analysis Department when the report is requested. This date span must match HHSC records regarding the effective dates of the combined entity's current contract(s). If there is a discrepancy, the accountability report will be rejected as unacceptable and returned for proper completion.

Do you request to aggregate by program those component codes held by this Combined Entity that participate in the Rate Enhancement program for the purpose of determining compliance with spending requirements?

If an entity operates two or more component codes that participate in the Attendant Compensation Rate Enhancement program, they may choose to have this group of contracts by program reviewed in the aggregate for the purposes of determining compliance with spending requirements.

Step 3 CONTRACT MANAGEMENT

Step 3a Verify Existing HHSC Component Codes and Contract Numbers:

3.a. Verify Contracts for Requested Reports

Active Entire Report Period?	Accountability Report Group Code	Contracting Entity Name	AR Type	Program	Site Type	Contract #	Contract Name	Enhancement Participation	Note
<input checked="" type="radio"/> Yes <input type="radio"/> No	100014001	ZZZ RAD ICF AR SMALL	ICF/IID-AR	ICF - Small ICF - Medium ICF - Large	small medium large	1000140011 1000140012 1000140013	ZZZ RAD ICF AR SMALL ZZZ RAD ICF AR MEDIUM ZZZ RAD ICF AR LARGE		<input type="text"/>

This list carries over from year to year. It is a list of all IDD program component codes and PHC and CLASS contracts operated by the provider’s combined entity grouped by AR Group Codes. For each AR group, the preparer must indicate in the left-most column whether the component code or all contracts in the AR Group were active during the entire AR period. If the answer to this question for a specific component code/contract is “No”, then an explanation must be entered in the Note column.

If the preparer believes that one or more additional component codes/contracts should be added to the prepopulated list or that a component code/contract included in the prepopulated list should be deleted, contact HHSC Rate Analysis at costinformation@hhsc.state.tx.us for assistance. Providers cannot add to or delete from this list independently. Failure to correctly verify this list may result in all STAIRS ARs for the combined entity being returned as unacceptable.

Site Type is applicable to ICF/IID only and refers to contracted facility size. A Small facility has 1-8 beds, a Medium facility has 9-13 beds, and a Large facility has 14+ beds.

Step 3b Enter Other Contracts, Grants or Business Relationships with the State of Texas or with any other Entity:

This list carries over from year to year. It is a list of all Texas and out-of-state business relationships in which the combined entity is involved. For each contract, grant or business, the preparer must indicate in the left-most column whether the contract, grant or business was active during the entire AR period. If the answer to this question for a specific contract, grant or business relationship is “No”, then an explanation must be entered in the Note column.

A preparer can add, edit or delete items from this list. Clicking Add will lead to the Add Contracts screen where all the necessary information can be added. See graphic below. Any changes to this list will trigger changes to the AR(s) for any other component code(s) controlled by the provider’s combined entity. If these other ARs are being completed by a different preparer who has verified Steps involving allocation, STAIRS will automatically unverify those Steps in those reports. The other preparer will need to address those Steps again prior to completing those reports.

3.b. Enter Other Business Components (Other Contracts, Grants or Business Relationships with the State of Texas or any other entity, or other funding sources)

Active Entire Reporting Period	Contract Type	Service Type	Contracting Entity Name	Contract # / Provider Identification	Added By	Note
<input type="button" value="Save"/> <input type="button" value="Save and Return"/> <input type="button" value="Cancel"/> <input type="button" value="Add Record"/> <input type="button" value="Edit"/> <input type="button" value="Delete Record"/>						

Information necessary to add an additional contract includes

- A. Was the contract active during the entire accountability report period? – If “No” is chosen, provider will be required to enter an explanation in the Notes section.
- B. Contract Type – The contract type will drive available options in Service Type below. Contracts which are neither state nor Medicare, such as contracts with related Day Habilitation entities, will be designated as “Other”.
- C. Service Type – The service type menu is driven by the Contract Type above. If the service type is not listed, the preparer should choose “Other”. If the preparer chooses “Other”, a box will appear for entry of the type of other contract, such as Day Habilitation contract.
- D. Contract # / Provider Identification – The contract number or other identifying information regarding the contract. For contracts that don’t have state or federal contracting numbers, this may be the legal name of the related organization with which the provider is contracting.

To Edit or Delete a contract, select it by clicking the round button to the far left beside that contract. Then choose an action, either Edit Record or Delete Record.

Step 3c Verify Contract Summary:

3.c. Verify Business Component Summary

Contract Type	Report Group Code	Contracting Entity Name	AR Type	Site Type
Are there any other contracts, grants, or business relationship with HHSC, the State of Texas, or with any other business entities not included in the summary table above?				
Yes <input type="radio"/> No <input checked="" type="radio"/>				
<input type="button" value="Save"/> <input type="button" value="Save and Return"/> <input type="button" value="Cancel"/>				

This screen lists all component codes, contracts, grants and business entities contained in **Steps 3a and 3b** above. Preparers must answer the question at the bottom of the page in order to clear the Stop Sign for this Step. The question “Are there any other contracts, grants, or business relationship with HHSC, the State of Texas, or with any other business entities not included in the summary table above?” must be answered either “Yes” or “No”. An answer of “Yes” will take the preparer to **Step 3b** above.

CONTRACTING ENTITY FINANCIAL DATA

Step 4 GENERAL INFORMATION

From this point forward in the instructions, all requested information must be reported based only on the contracting entity and program for which the accountability report is being prepared.

4. General Information

	Proprietary (For Profit)	Nonprofit Corporation	Nonprofit Association	Government
Type of Ownership of Contracting Entity	<input type="radio"/> Sole Proprietor <input type="radio"/> Partnership <input type="radio"/> Limited Partnership <input type="radio"/> Limited Liability Company <input type="radio"/> "S" Corporation <input type="radio"/> Corporation	<input type="radio"/> Owned or affiliated with religious organization <input type="radio"/> Not owned or affiliated with religious organization	<input type="radio"/> Owned or affiliated with religious organization <input type="radio"/> Not owned or affiliated with religious organization	<input type="radio"/> State <input type="radio"/> County <input type="radio"/> Municipal <input type="radio"/> Special District <input type="radio"/> Federal <input type="radio"/> MH/MR Center (all component codes between 010 and 500)
Contracted Provider Report Period Beginning (mm/dd/yyyy)	06/01/2018			
Contracted Provider Report Period Ending (mm/dd/yyyy)	03/01/2019			
Is provider a participant in Rate Enhancement for the entire reporting period for this accountability report group for ICF/IID Day Habilitation services?				
Is provider a participant in Rate Enhancement for the entire reporting period for this accountability report group for ICF/IID Residential services?				
Was an accrual method of accounting used for reporting all revenues, expenses, and statistical information on this report except for where the instructions require otherwise?	<input type="checkbox"/>			
Does the provider have work papers that clearly reconcile between the fiscal year trial balance and the amounts reported on this report? If No, please provide an explanation.	<input type="checkbox"/>			

Type of Ownership of Contracting Entity:

Identify the type of ownership of the provider contracting entity from the list. Note: If the provider is a for-profit corporation or one segment of a for-profit corporation (e.g. a dba of a for-profit corporation), "Corporation" is the appropriate entry.

Contracted Provider Reporting Period Beginning and Ending Dates:

These dates represent the beginning and ending dates for the contracted provider's reporting period. For a contracted provider that submitted an accountability report in a prior year, these dates will be based on the dates from the prior accountability report. For a contracted provider that is reporting for the first time this year, the dates are based on the beginning date of the first contract and on the assumption that the provider is on a calendar fiscal year, so has an ending date of 12/31 of the accountability report year. If these dates are not correct, contact HHSC Rate Analysis at costinformation@hhsc.state.tx.us for assistance.

Beginning and Ending Dates When the Component Code Did Not Have At Least One Contract Active for the Provider's Entire Fiscal Year Ending in 2018:

In situations where the component code did not have at least one contract active for the provider's entire fiscal year ending in 2018, the reporting period must match with HHSC records regarding the effective dates of the provider's current contract(s).

If there is a difference in the beginning dates for the ICF/IID contracts under the component code, the earliest beginning date will be used. If this date is prior to the first day of the provider's fiscal year ending in 2018, the first day of the provider's fiscal year will be used, based on the ending date from the prior year's AR.

If there is a difference in the ending dates for the ICF/IID contracts under the component code, the latest date will be used. If this date is after the last day of the provider's fiscal year ending in 2018, the last day of the provider's fiscal year will be used.

If the provider's component code is new or was acquired during the 2018 reporting period, complete the AR for the period beginning with the initial date of the provider's first contract and ending with the last day of the last month of the provider's fiscal year ending

in 2018 Refer to 1 TAC §355.105(b)(5) for additional information on the cost-reporting year.

If the provider's reporting period is less than twelve months, the AR preparer must properly report only those statistics, revenues and expenses associated with the reporting period. For example, if the provider's reporting period was 2/1/18 through 12/31/18, it is unacceptable for the AR preparer to report 11/14 of the provider's annual days of service, annual revenues, and annual expenses. Instead, the AR preparer should only report information related to the reporting period, meaning that days of service, revenues, and costs related to the month of January 2018 are not to be included anywhere on the AR.

If the reporting period does not begin on the first day of a calendar month or end on the last day of a calendar month, it is imperative that the preparer properly report only those statistics (i.e., days of service), revenues, and costs associated with the actual cost-reporting period. If, for example, the provider's cost-reporting period was 8/15/18 through 12/31/18, it is unacceptable for the preparer to report 37.8% of the provider's total days of service, revenues, and costs for the year. Rather, the preparer must report the days of service, revenues and costs associated only with the period 8/15/18 through 12/31/18. Since the month of August is partially reported (i.e., 8/15 - 8/31), the preparer will have to calculate 17/31 of various costs applicable to the month of August (e.g., building rent/depreciation, August utilities, and other such "monthly" costs) and include that with the actual costs for September - December. For questions regarding the appropriate method for reporting information for less than a full year, please contact the Rate Analysis Customer Information Center.

Is provider a participant in Attendant Compensation Rate Enhancement for Day Habilitation Services?

This answer will be prepopulated and based on whether the provider was a participant for the entire accountability reporting period. If the prepopulated answer appears to be incorrect, please contact the Rate Analysis at costinformation@hsc.state.tx.us.

Is provider a participant in Attendant Compensation Rate Enhancement for Residential Services?

This answer will be prepopulated and based on whether the provider was a participant for the entire accountability reporting period. If the prepopulated answer appears to be incorrect, please contact the Rate Analysis at costinformation@hsc.state.tx.us.

Was an accrual method of accounting used for reporting all revenues, expenses and statistical information on this report, except for where instructions require otherwise?

Click either "Yes" or "No". If "No", provide a reason in the Explanation Box. For the definition of the accrual method of accounting, see the **Definitions** section. An accrual method of accounting must be used in reporting information on Texas Medicaid cost reports in all areas except those in which instructions or cost-reporting rules specify otherwise. Accountability reports submitted using a method of accounting other than accrual will be returned to the provider, unless the provider is a governmental entity (i.e., Type of Ownership is in the Government column) using the cash method or modified accrual method. Refer to 1 TAC §355.105(b)(1) for additional information on accounting methods.

Did the preparer(s) of this report review the most recently received audit adjustments and make the necessary revisions when preparing this report?

Click either "Yes" or "No". If the answer is "No", provide an Explanation. Each provider should review the most recent AR audit results (desk review or field audit) and make any necessary changes to the current ARs. (Refer to 1 TAC §355.107.) If the provider is in the process of appealing an audit adjustment when the current AR is submitted, the preparer is still required to make any necessary changes resulting from the prior AR audit or informal review decision. The provider may include an explanation of the provider's disagreement with the manner in which a particular cost has been required to be reported as a result of the previous audit or informal review.

Does the provider have work papers that clearly reconcile between the fiscal year trial balance and the amounts reported on this report?

Click either "Yes" or "No". When provider clicks "Yes", then the workpapers must be uploaded to the report. There should not be situations where a providers responds to this question with "no". Each provider must maintain reconciliation work papers and any additional supporting work papers (such as invoices, canceled checks, tax reporting forms, allocation spreadsheets, financial statements, bank statements, and any other documentation to support the existence, nature, and allowability of reported information) detailing allocation of costs to all contracts/grants/programs/business entities. In order to facilitate the audit process, it is thus required that the AR preparer attach a reconciliation worksheet, with its foundation being the provider's year-end trial balance. Refer to 1 TAC §355.105(b)(2)(A).

Step 5 DAYS OF SERVICE AND OTHER REVENUE

Important Note. There IS no location for entering Medicaid revenues for ICF/IID service provision. Those revenues are not to be entered in the AR.

5. Days of Service and Revenue Entry

Units of Service				
Service	Rate Period 1 06/01/2018 - 08/31/2018	Rate Period 2 09/01/2018 - 03/01/2019	Total Medicaid	Non-Medicaid Revenues
Small Facility LON 1	<input type="text"/>	<input type="text"/>	0	
Small Facility LON 5	<input type="text"/>	<input type="text"/>	0	
Small Facility LON 8	<input type="text"/>	<input type="text"/>	0	
Small Facility LON 6	<input type="text"/>	<input type="text"/>	0	
Small Facility LON 9	<input type="text"/>	<input type="text"/>	0	
Small Facility Non Medicaid	<input type="text"/>	<input type="text"/>	0	<input type="text"/>
TOTAL	0	0	0	\$0

Units of Service				
Service	Rate Period 1 06/01/2018 - 08/31/2018	Rate Period 2 09/01/2018 - 03/01/2019	Total Medicaid	Non-Medicaid Revenues
Medium Facility LON 1	<input type="text"/>	<input type="text"/>	0	
Medium Facility LON 5	<input type="text"/>	<input type="text"/>	0	
Medium Facility LON 8	<input type="text"/>	<input type="text"/>	0	
Medium Facility LON 6	<input type="text"/>	<input type="text"/>	0	
Medium Facility LON 9	<input type="text"/>	<input type="text"/>	0	
Medium Facility Non Medicaid	<input type="text"/>	<input type="text"/>	0	<input type="text"/>
TOTAL	0	0	0	\$0

Units of Service				
Service	Rate Period 1 06/01/2018 - 08/31/2018	Rate Period 2 09/01/2018 - 03/01/2019	Total Medicaid	Non-Medicaid Revenues
Large Facility LON 1	<input type="text"/>	<input type="text"/>	0	
Large Facility LON 5	<input type="text"/>	<input type="text"/>	0	
Large Facility LON 8	<input type="text"/>	<input type="text"/>	0	
Large Facility LON 6	<input type="text"/>	<input type="text"/>	0	
Large Facility LON 9	<input type="text"/>	<input type="text"/>	0	
Large Facility Non Medicaid	<input type="text"/>	<input type="text"/>	0	<input type="text"/>
TOTAL	0	0	0	\$0

In this screen the preparer will enter the Medicaid days of service by facility size and Level of Need (LON) and the Non-Medicaid units of service and related Non-Medicaid revenues by facility size. The provider must breakdown the Medicaid units into multiple rate periods based on when the Medicaid payment rates changed during the provider’s AR year. There will be separate entries for each rate period based on the provider’s reporting period in **Step 4**. The data should be reported based on the date of service provision and not by the date revenues were received – in other words, on the accrual basis. Bed holds or room holds are not considered units of service.

Non-Medicaid revenues include revenues received for Private residents in Medicaid-Contracted beds and revenues received for residents in Non-Medicaid-Contracted beds.

Step 6. Wages and Compensation

Step 6.a. General Information

6a. General Information

Did your company offer health insurance to its employees on or before March 23, 2010? *	<input type="radio"/> Yes <input type="radio"/> No
Does the health insurance your company offers include all of the following benefits: inpatient, outpatient and emergency services; maternity and newborn care; mental and behavioral health services; prescription drugs; rehabilitation and habilitation services; laboratory services; disease management; preventative and wellness services; pediatric care? (If your company does not offer health insurance, answer 'No'.) *	<input type="radio"/> Yes <input type="radio"/> No
Do you have any Related-Party Wages and Compensation (Employee or Contractor) included in the Accountability Report? *	<input type="radio"/> Yes <input type="radio"/> No
Do you have any <u>Related Party</u> contracted Day Habilitation? *	<input type="radio"/> Yes <input type="radio"/> No
Do you have any Non-Related Party contracted Day Habilitation? *	<input type="radio"/> Yes <input type="radio"/> No
Have the attendants, whose data is reported in Step 6c, performed attendant functions at least 80% of their total time worked?	<input type="text" value=""/>

Did your company offer health insurance to its employees on or before March 23, 2010? If "Yes", is that coverage still in effect? Click "Yes" or "No" to each question.

Does the health insurance your company offers include all of the following benefits: inpatient, outpatient and emergency services; maternity and newborn care; mental and behavioral health services; prescription drugs; rehabilitation and habilitation services; laboratory services; disease management; preventative and wellness services; pediatric care? (If your company does not offer health insurance, answer "No".):

Do you have any Related-Party Wages and Compensation (Employee or Contractor) included in the Accountability Report?

Click "Yes" or "No". See **DEFINITIONS, RELATED PARTY**) to determine if provider must report a related party. If the preparer clicks "Yes" then the Step on the main Wages and Compensation page called

Step 6.b. (Related-Party Wages and Compensation) will be activated for entry.

Do you have any Related-Party contracted Day Habilitation?

Click either "Yes" or "No". If "Yes", you must report all staff costs from the Related Party contracted Day Habilitation provider in **Step 6c**.

Do you have any Non-Related-Party contracted Day Habilitation?

Click either "Yes" or "No". If "Yes", report the number of days of contracted non-related party Day Habilitation and the total cost.

Step 6.b. Related-Party Wages and Compensation.

This Step will be grey and the preparer will not be able to make entries if the answer was "No" to the question regarding Related Party Wages and Compensation on **Step 6.a.** above. If that question was erroneously answered "No", the preparer will need to return to that item and change the response to "Yes" to be able to enter data in this Step.

Create one and only one record for each individual. If the individual worked in multiple entities or for multiple contracts, that will be designated in # 2 below.

For each owner-employee, related-party employee and/or related-party contract staff:

1. Click "Add record"

6b. Related-Party

First Name	Middle Initial	Last Name	Suffix	Birth Date (mm/dd)	Relationship to Provider	Percentage Ownership (if no ownership, enter 0)	Total Hours Worked	Total Compensation	Hourly Wage Rate	Is Allocation Complete

- A. First Name
- B. Middle Initial
- C. Last Name
- D. Suffix – e.g. Jr., III, Sr.
- E. Birth Date – Format as mm/dd (e.g. 10/26 for October 26). Year is not requested.
- F. Relationship to Provider – This could be blood relationship (Father, Sister, Daughter, Aunt), marriage relationship (Wife, Mother-in-Law, Brother-in-Law), Ownership (in the case of a corporation or partnership), or control (membership in board of directors, membership in related board of directors, etc.)
- G. Percentage Ownership (in cases of corporation or partnership)
- H. Total Hours Worked – Total hours worked for all entities within the entire combined entity. If the related party was paid for a "day of service", then multiply that day by 8 to report hours.
- I. Total Compensation – Total compensation (wages, salary and/or contract payments) paid to the related party by all entities within the entire combined entity. It is expected that all individuals will have received some form of compensation from within the combined entity.

Note: This must be actual compensation, without any adjustments based on related-party status. Any adjustments required by 1 TAC 355.105(i) will be made automatically in STAIRS during the audit process.

- J. Hourly Wage Rate – Calculated figure based on Total Compensation divided by Total Hours Worked.

Note: If the preparer needs to delete a related-party after filling out the data fields for A thru J listed above, preparer must zero out the Total Hours Worked as well as the Hours listed on the grey bar. Click on the individual to delete and on Delete Record.

2. Click "Save" to enter Business Component and Line Item Allocation(s)

The available business components are limited to the businesses and contracts entered in **Step 3**. Allocate or direct cost all hours reported for the individual under Total Hours Worked and Total Compensation to a business component before proceeding. The Hourly Wage Rate will automatically be calculated. If allocated, an allocation method must be chosen and an allocation summary uploaded when prompted.

6b. Related-Party

First Name	Middle Initial	Last Name	Suffix	Birth Date (mm/dd)	Relationship to Provider	Percentage Ownership (if no ownership, enter 0)	Total Hours Worked	Total Compensation	Hourly Wage Rate

Business Component & Line Item Allocation

		Hours	Compensation
TOTAL		.50	\$0
Select Business Component Allocation Methodology		Attach Methodology	
<input type="text"/>		<input type="text"/>	

- Business Component – The drop-down menu includes all business components for the provider entity. If provider entity only has one business component, the drop down menu does not appear and the single business component is automatically entered under business component.
- Click "Add Record" – Generates additional lines to record Line Item information for each business component. Choose and Click "Add Record" until all business components to which this related party will be allocated have been added.

6.b. RELATED-PARTY WAGES AND COMPENSATION

First Name	Middle Initial	Last Name	Suffix	Birth Date (mm/dd)	Relationship to Provider	Percentage Ownership (if no ownership, enter 0)	Total Hours Worked	Total Compensation	Hourly Wage Rate

Business Component & Line Item Allocations

977- CBA

Line Item	Site Type	Job Title	Position Type	Description of Duties	Employed/Contracted	Total Hours Worked	Compensation	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Attach Organizational Chart 1							Attach Organizational Chart 2 (Optional)	
<input type="text"/>							<input type="text"/>	
Select Line Item Allocation Methodology							Attach Methodology	
<input type="text"/>							<input type="text"/>	
TOTAL								
Select Business Component Allocation Methodology							Attach Methodology	
<input type="text"/>							<input type="text"/>	

- Hours – On the grey bar, enter hours allocated or direct costed to each business component. Compensation amount will be automatically calculated.
- Line Item – The drop-down menu includes all staff types reportable in this cost report. Attendant staff types may only be used for staff who meet the definition of attendant. See Definitions, *Attendant Care for Community*. Note both which staff can be classified as an attendant, and which cannot.
- Job Title – Related Party's title within the specific business component
- Position Type - Identify the type of position (e.g., central office, management, administrative, direct care, nurse, or direct care supervisory) filled by the related individual.
- Description of Duties – Provide a description of the duties performed by the related individual as they relate to the specific cost report or upload a copy of the person's

written job description, providing a summary of how those duties relate to the specific cost report, and reference that upload in this item.

- F. Employed/Contracted –Select either Contracted or Employed. If it happens that the related party is compensated during the year both as an employee and as a contractor for the same activity, then the hours for contracted would have to be entered separately from the hours for employed.
- G. Total Hours Worked – Enter hours allocated or direct costed to each area. Allocate or direct cost all hours reported for the individual for the business component to an area before proceeding. Compensation will automatically be calculated.
- H. Organizational chart – Upload an organizational chart or select from the drop down menu of documents that have already been uploaded.
- I. Line Item Allocation Methodology – If allocated to multiple line items, an allocation method must be chosen and an allocation summary uploaded. This will be required only if there were multiple line items entered.
- J. Business Component Allocation Methodology – After all business component line item allocations have been completed, reporting a related party in multiple business components will also require that a business component allocation method be chosen and an allocation summary uploaded.

Step 6.c. Attendant Non-Related Party Wages and Benefits

6c. Attendant

Small Facility

Type	Non-Related Party				Related Party				Related Party and Non-Related Party			Total Compensation M [(C+E+G+H+J+L)]	Average Staff Rate N [(C+G)/(B+F)]	Average Contracted Rate O [(E+H)/(D+I)]	Average Mileage Reimbursement per mile P (L/K)
	Total Staff Hours	Total Staff Wages	Total Contracted Hours	Total Contracted Payment	Total Staff Hours	Total Staff Wages	Total Contracted Hours	Total Contracted Payment	Employee Benefits/Insurance	Miles Traveled	Mileage Reimbursement				
A	B	C	D	E	F	G	H	I	J	K	L				
Residential - Attendant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>	<input type="text"/>	<input type="text"/>	\$0	\$0.00	\$0.00	\$0.00
Day Habilitation - Attendant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>	<input type="text"/>	<input type="text"/>	\$0	\$0.00	\$0.00	\$0.00
TOTAL	0.00	\$0	0.00	\$0	0.00	\$0	0.00	\$0	\$0	0	\$0	\$0			

Medium Facility

Type	Non-Related Party				Related Party				Related Party and Non-Related Party			Total Compensation M [(C+E+G+H+J+L)]	Average Staff Rate N [(C+G)/(B+F)]	Average Contracted Rate O [(E+H)/(D+I)]	Average Mileage Reimbursement per mile P (L/K)
	Total Staff Hours	Total Staff Wages	Total Contracted Hours	Total Contracted Payment	Total Staff Hours	Total Staff Wages	Total Contracted Hours	Total Contracted Payment	Employee Benefits/Insurance	Miles Traveled	Mileage Reimbursement				
A	B	C	D	E	F	G	H	I	J	K	L				
Residential - Attendant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>	<input type="text"/>	<input type="text"/>	\$0	\$0.00	\$0.00	\$0.00
Day Habilitation - Attendant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>	<input type="text"/>	<input type="text"/>	\$0	\$0.00	\$0.00	\$0.00
TOTAL	0.00	\$0	0.00	\$0	0.00	\$0	0.00	\$0	\$0	0	\$0	\$0			

Large Facility

Type	Non-Related Party				Related Party				Related Party and Non-Related Party			Total Compensation M [(C+E+G+H+J+L)]	Average Staff Rate N [(C+G)/(B+F)]	Average Contracted Rate O [(E+H)/(D+I)]	Average Mileage Reimbursement per mile P (L/K)
	Total Staff Hours	Total Staff Wages	Total Contracted Hours	Total Contracted Payment	Total Staff Hours	Total Staff Wages	Total Contracted Hours	Total Contracted Payment	Employee Benefits/Insurance	Miles Traveled	Mileage Reimbursement				
A	B	C	D	E	F	G	H	I	J	K	L				
Residential - Attendant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>	<input type="text"/>	<input type="text"/>	\$0	\$0.00	\$0.00	\$0.00
Day Habilitation - Attendant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>	<input type="text"/>	<input type="text"/>	\$0	\$0.00	\$0.00	\$0.00
TOTAL	0.00	\$0	0.00	\$0	0.00	\$0	0.00	\$0	\$0	0	\$0	\$0			

Columns B-E: Non-Related Party Total Staff Hours, Total Staff Wages, Total Contract Hours and Total Contract Payment: These columns are for non-related party attendants ONLY. For each facility size (Small, Medium and Large) and for each attendant staff type (Residential and Day Habilitation) enter hours, wages and contract compensation for non-related party employees and contract staff who meet the definition of an attendant. See **DEFINITIONS, ATTENDANT CARE**. Only employee and contracted staff who meet the definition of attendant may be reported in these cost items.

Total Staff and Contract Hours should include the total number of hours for which employees and contract labor attendants were compensated during the reporting period. This would include hours for both time worked and paid time off (sick leave, vacation, etc.).

SPECIAL NOTE RELATING TO REPORTING OF CONTRACTED DAY HABILITATION.

If the provider has Attendant personnel who work in their Day Habilitation facility and are paid as an attendant on a contract basis, they may be reported here as Contracted Staff.

If the staff are paid the full Day Habilitation rate, and not just an attendant portion, then treat them either as if they are a 3rd-party Day Habilitation entity or as if they are a related-party Day Habilitation entity depending on the relationship.

- If the provider contracts with a related-party Day Habilitation entity, report the properly allocated Attendant costs here as if they were the provider's own staff.

Columns F-I: Related-Party Total Staff Hours, Total Staff Wages, Total Contract Hours and Total Contract Payment: If there are related-party employee and/or contract attendant staff reported in **Step 6b** above, these columns are automatically populated after all nonrelated-party costs in Columns B-E have been entered.

Column J: Employee Benefits/Insurance: This column is for BOTH related and non-related party employee attendant staff. For all attendants, by facility size and staff type, include the following benefits in this column. These benefits, with the exception of paid claims where the employer is self-insured, must be direct costed, not allocated.

- Accrued Vacation and Sick Leave*
- Employer-Paid Health/Medical/Dental Premiums
- Employer-Paid Disability Insurance Premiums
- Employer-Paid Life Insurance Premiums
- Employer-Paid Contributions to acceptable retirement funds/pension plans
- Employer-Paid Contributions to acceptable deferred compensation funds
- Employer-Paid Child Day Care
- Employer-Paid Claims for Health/Medical/Dental Insurance when the provider is self-insured (may be allocated)

* ACCRUED LEAVE. If the provider chooses to report accrued leave expenses not yet subject to payroll taxes, they must be reported as employee benefits. Providers must maintain adequate documentation to substantiate that costs reported one year as accrued benefits are not also reported, either the same or another year, as salaries and wages. 1 TAC §355.103(b)(1)(A)(iii)(III)(-c-).

Columns K and L: Miles Traveled and Mileage Reimbursement: These columns are for BOTH related and non-related party employee attendant staff. For all attendants, by facility size and staff type, include the personal vehicle miles traveled and the mileage reimbursement paid for allowable travel and transportation in the staff person's personal vehicle. Allowable travel and transportation includes mileage and reimbursements of attendant staff who transport individuals to/from services and activities of the ICF/IID in their personal vehicle, unless payroll taxes are withheld on the reimbursements, in which

case they should be included as salaries and wages of the appropriate staff. Allowable travel and transportation also includes mileage and reimbursements of attendant staff for allowable training to which they traveled in their personal vehicle.

The maximum allowable mileage reimbursement is as follows:

- 1/1/18 - 12/31/18 54.5 cents per mile
- 1/1/19 - 12/31/19 58.0 cents per mile

Column M: Total Compensation: This column is the sum of Columns C, E, G, I, J and L and represents Total Attendant Compensation for that facility type and staff type.

Column N: Average Staff Rate: This column is the result of Columns C + G divided by Columns B + F and represents the average hourly wage rate of all employee staff, both related party and non-related party.

Column O: Average Contract Rate: This column is the result of Columns E + I divided by Columns D + H and represents the average hourly contract rate of all contract staff, both related party and non-related party.

Column P: Average Mileage Reimbursement per Mile: This column is the result of Column L divided by Column K. This amount should never be greater than the highest allowable mileage rate for the provider’s fiscal year.

Step 7. Payroll Taxes and Workers’ Compensation

Report costs for all staff in Step 7. Report costs for attendant staff, non-attendant / program administration (non-central office) employees and central office employees separately.

If payroll taxes (i.e. FICA, Medicare, and state/federal unemployment) are allocated based upon percentage of salaries, the provider must disclose this functional allocation method. The use of percentage of salaries is not the salaries allocation method, since the salaries allocation method includes both salaries and contract labor.

7. Payroll Taxes and Workers' Compensation

Did the provider have a Section 125 or Cafeteria Plan that covers the employees for insurance premiums, unreimbursed medical expenses and/or dependent care costs?	<input type="radio"/> Yes <input type="radio"/> No
Is your entity a Texas Workforce Commission Reimbursing Employer (e.g., not required to pay quarterly taxes to the Texas Workforce Commission (TWC for unemployment coverage)?	<input type="radio"/> Yes <input type="radio"/> No
Taxes and Workers' Compensation	
FICA and Medicare Payroll Taxes	<input type="text"/>
State and Federal Unemployment Taxes	<input type="text"/>
Workers' Compensation Premiums	<input type="text"/>
Workers' Compensation Paid Claims	<input type="text"/>
<input type="button" value="Save"/> <input type="button" value="Save and Return"/> <input type="button" value="Cancel"/>	

Did the provider have a Section 125 or Cafeteria Plan that covers the employees for insurance premiums, unreimbursed medical expenses and/or dependent care costs?

Click either “Yes” or “No”. If “Yes” is clicked, provider must upload supporting documentation or select a file from the drop down menu of documents that have already been uploaded.

Is your entity a Texas Workforce Commission Reimbursing Employer?

Click either "Yes" or "No". If "Yes" is clicked, provider must upload supporting documentation or select a file from the drop down menu of documents that have already been uploaded.

For the following taxes, list separately, those for Non-Central Office and for Central Office staff:

FICA & Medicare Payroll Taxes

Report the cost of the employer's portion of these taxes. Do not include the employee's share of the taxes. Unless the provider has indicated that they participate in a Section 125 or Cafeteria Plan that covers the employees for insurance premiums, unreimbursed medical expenses and/or dependent care costs or the provider has reported staff who are paid in excess of the FICA Wage Limit (\$128,400 for 2018), this amount must equal 7.65% of reported wages.

State and Federal Unemployment Taxes

Report both federal (FUTA) and Texas state (SUTA) unemployment expenses.

Workers' Compensation Premiums

If the contracted provider is a subscriber to the Workers' Compensation Act, report here the Worker's Compensation insurance premiums paid to the provider's commercial insurance carrier. If the effective period of the provider's Workers' Compensation insurance policy does not correspond to the provider's fiscal year, it will be necessary to prorate the premium costs from the two policy periods falling within the provider's reporting period to accurately reflect the costs associated with the cost-reporting period. Premium costs include the base rate, any discounts for lack of injuries, any refunds for prior period overpayments, any additional modifiers and surcharges for experiencing high numbers of injuries (such as being placed in a risk pool), and any audit adjustments made during the cost-reporting period. The Texas Workers' Compensation Commission audits traditional Workers' Compensation insurance policies yearly and annual adjustments must be properly applied to the cost-reporting period on a cash basis.

If the contracted provider is not a subscriber to the Workers' Compensation Act, there are alternate insurance premium costs that can be reported in this item. Acceptable alternate insurance policies include industrial accident policies and other similar types of coverage for employee on-the-job injuries. Disability insurance and health premiums are **not** considered alternate workers' compensation policies and those costs must be reported as employee benefits (if subject to payroll taxes, they must be reported as salaries). A general liability insurance policy, according to the Texas Department of Insurance, specifically excludes payment for employee on-the-job injuries; therefore, general liability premium costs must not be reported on this item.

If the provider's commercially purchased insurance policy does not provide total coverage and has a deductible and/or coinsurance clause, any deductibles and/or coinsurance payments made by the employer on behalf of the employee would be considered claims paid (i.e., self-insurance) and must be reported in the **Workers' Compensation Paid Claims** item below.

Workers' Compensation Paid Claims

If the provider was not a subscriber to the Workers' Compensation Act (i.e., traditional workers' compensation insurance policy), and paid workers' compensation claims for employee on-the-job injuries, report the amount of claims paid. Also report the part of any workers' compensation litigation award or settlement that reimburses the injured employee for lost wages and medical bills here unless the provider is ordered to pay the award or settlement as back wages subject to payroll taxes and reporting on a W-2, in which case the cost should be reported in **Step 6**. Note that only the part of the litigation award or settlement that reimburses the injured employee for lost wages and medical bills is allowable on this cost report. If the provider maintained a separate bank account for the sole purpose of paying workers' compensation claims for employee on-the-job injuries (i.e., a nonsubscriber risk reserve account), the contributions made to this account are not allowable on the cost report. This type of arrangement requires that the contracted provider be responsible for payment of all its workers' compensation claims and is not an insurance-type account or arrangement. A nonsubscriber risk reserve account is not required to be managed by an independent agency or third party. It can be a separate checking account set aside by the contracted provider for payment of its workers' compensation claims. However, only the amount for any claims paid should be reported on the cost report, not the amount contributed to any (reserve) account. There is a cost ceiling to be applied to allowable self-insurance workers' compensation costs or costs where the provider does not provide total coverage and that ceiling may limit the costs, which may be reported. See 1 TAC §355.103(b)(13)(B) and §355.105(b)(2)(B)(ix) and **Appendix E**.

Online Verification and Submission

Step 9. Preparer Verification Summary

9. Preparer Verification Summary

Revenue Summary	
Total Non-Medicaid	\$0
TOTAL REVENUE	\$0.00

Expense Summary	
Total Attendant Wages, Benefits and Mileage	\$0
Total Payroll Taxes & Workers' Compensation (Not including Central Office)	\$0
TOTAL REPORTED EXPENSES	\$0.00

For more detailed information, click on the link to view the [Preparer Verification Detail](#).

I verify that the information entered is correct.

If you need assistance, please contact the RAD Customer Information Center at (512) 424-6637 or RAD-LTSS@hsc.state.tx.us

After all items for the accountability report have been completed, the report is ready for verification. The summary verification screen shows the Total Reported Revenues and Total Reported Expenses entered into STAIRS. These figures should be checked against the preparer's work papers to assure that all intended non-Medicaid revenues and expenses have been entered.

A link to the Preparer Verification Detail Report is included at the bottom of the page. This provides the detail of all units of service and expenses entered.

Once the preparer has determined that everything is entered correctly, the report can be verified. The preparer will check the box beside the phrase "I verify that the information entered is correct". Then click the Verify box at the bottom.

Steps 10. Preparer Certification

Certification pages cannot be printed for signing and notarizing until the report has been verified. If the report is reopened for any reason, any previously uploaded certifications will be invalidated and must be completed again.

A preparer may print out both the Preparer and Entity Contact Certification pages at the same time. Once one of the Certification pages is printed, the cost report is completed and locked. If it is discovered that additional changes need to be made, the preparer must contact costinformation@hsc.state.tx.us for assistance in getting the report(s) reopened.

Certification pages must contain original signatures and original notary stamps/seals when uploaded to STAIRS. These pages must be maintained in original form by the provider. If these pages are not properly completed, the cost report will not be processed until the provider uploads completed pages; if completed pages are not uploaded in a timely manner, the cost report will not be counted as received timely and may be returned. If a report is returned, it is unverified and new certifications, dated after the report has been re-verified will have to be uploaded.

Preparer (Methodology) Certification

This page must be signed by the person identified in **Step 1** of this cost report as *Preparer*. This person must be the individual who actually prepared the cost report or who has primary responsibility for the preparation of the cost report for the provider. Signing as *Preparer* carries the responsibility for an accurate and complete cost report prepared in accordance with applicable methodology rules and instructions. Signing as *Preparer* signifies that the preparer is knowledgeable of the applicable methodology rules and instructions and that the preparer has either completed the cost report himself/herself in accordance with those rules and instructions or has adequately supervised and thoroughly instructed his/her employees in the proper completion of the cost report. Ultimate responsibility for the cost report lies with the person signing as *Preparer*. If more than one person prepared the cost report, an executed Preparer Certification page (with original signature and original notary stamp/seal) may be submitted by each preparer. All persons signing the methodology certification must have attended the required cost report training.

AS PREPARER OF THIS ACCOUNTABILITY REPORT, I HEREBY CERTIFY THAT:

- I have completed the state-sponsored cost report training for this accountability report.
- I have read the note below, the cover letter and all the instructions applicable to this accountability report.
- I have read the Cost Determination Process Rules (excluding 24-RCC), program rules, and reimbursement methodology applicable to this cost report, which define allowable and unallowable costs and provide guidance in proper cost reporting.
- I have reviewed the prior year's cost report audit adjustments, if any, and have made the necessary revisions to this period's cost report.
- To the best of my knowledge and belief, this cost report is true, correct and complete, and was prepared in accordance with the Cost Determination Process Rules (excluding 24 RCC), program rules, reimbursement methodology and all the instructions applicable to this cost report.
- This accountability report was prepared from the books and records of the contracted provider and/or its controlling entity.

Note: This PREPARER CERTIFICATION must be signed by the individual who prepared the cost report or who has the primary responsibility for the preparation of the cost report. If more than one person prepared the cost report, an executed PREPARER CERTIFICATION may be submitted by each preparer. Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment.

The Preparer Certification must be uploaded by the Preparer, using his/her own login information.

PREPARER IDENTIFICATION

Name of Contracted Provider:

Printed/Typed Name of Signer:

Title of Signer:

SIGNATURE OF PREPARER

Subscribed and sworn before me, a Notary public on the

DATE

____ of _____
Day Month Year

Notary Signature

Notary Public, State of

Commission Expires

Save Save and Return Cancel

10.a. Upload Preparer Certification

The Preparer Certification must be uploaded by the Preparer, using his/her own login information.

Upload Preparer Certification Select file or upload new file

Save Save and Return Cancel

Step 11. Entity Contact Certification

Certification pages must contain original signatures and original notary stamps/seals when uploaded to STAIRS. These pages must be maintained in original form by the provider. If these pages are not properly completed, the accountability report will not be processed until the provider uploads completed pages; if completed pages are not uploaded in a timely manner, the accountability report will not be counted as received timely and may be returned. If a report is returned, it is unverified and new certifications, dated after the report has been re-verified will have to be uploaded.

Entity Contact Certification

This page must be completed and signed by an individual legally responsible for the conduct of the provider such as an owner, partner, Corporate Officer, Association Officer, Government official, or L.L.C. member. The HCS/TxHmL administrator may not sign this certification page unless he/she also holds one of those positions. The responsible party's signature must be notarized. The signature date must be the same or after the date the preparer signed the Preparer Certification page, since the accountability report certification indicates that the accountability report has been reviewed after preparation.

AS SIGNER OF THIS ACCOUNTABILITY REPORT, I HEREBY CERTIFY THAT:

- I have read the note below, the cover letter and all the instructions applicable to this accountability report.
- I have read the Cost Determination Process Rules (excluding 24-RCC), program rules, and reimbursement methodology applicable to this cost report, which define allowable and unallowable costs and provide guidance in proper cost reporting.
- I have reviewed this cost report after its preparation.
- To the best of my knowledge and belief, this cost report is true, correct and complete, and was prepared in accordance with the Cost Determination Process Rules (excluding 24 RCC), program rules, reimbursement methodology and all the instructions applicable to this cost report.
- This accountability report was prepared from the books and records of the contracted provider and/or its controlling entity.

Note: This ACCOUNTABILITY REPORT CERTIFICATION must be signed by the individual legally responsible for the conduct of the contracted provider, such as the Sole Proprietor, a Partner, a Corporate Officer, an Association Officer, or a Governmental Official. The administrator/director is authorized to sign only if he/she holds one of these positions. Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment.

The Accountability Report Certification must be uploaded by the responsible party, using his/her own login information.

SIGNER IDENTIFICATION

Name of Contracted Provider:

Printed/Typed Name of Signer:

Title of Signer:

Name of Business Entity:

Address of Signer (street or P.O. Box, city, state, 9-digit zip):

Phone Number (including area code):

FAX Number (including area code):

Email:

SIGNATURE OF PREPARER

DATE


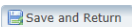

Subscribed and sworn before me, a Notary public on the

____ of _____, _____
Day Month Year

Notary Signature

Notary Public, State of

Commission Expires

 Save  Save and Return  Cancel

11.a. Upload Cost Report Certification

The Cost Report Certification must be uploaded by the responsible party, using his/her own login information.

Upload Cost Report Certification Select file or upload new file

Save Save and Return Cancel

Step 12. Provider Adjustment Report

Review Period Expires: February 04, 20XX

In accordance with Title 1 Texas Administrative Code (TAC) §355.107(a), the following report shows adjustments made to your cost report by the Texas Health and Human Services Commission (HHSC). This report shows changes made to values originally reported by the preparer and includes the original amount reported, the amount of adjustment, the amount after adjustment, and the reason for the adjustment. Please note that at the time your report was processed the reported units of service were reconciled to the most recently available, reliable units of service for the reporting period, as reflected in the State's Claim Management System (CMS).

Not shown are the calculated values that changed due to these adjustments. To better understand the overall impact of these adjustments on the total revenues and expenses, you are being provided a Summary Table at the bottom of the report.

It is important that you carefully review this information. You may obtain additional information concerning these adjustments by submitting a written request by United States (U.S.) Mail or special delivery to:

Texas Health and Human Services Commission
 Rate Analysis Department, MC H-400
 P.O. Box 149030
 Austin, TX 78714-9030

General and Statistical

Step	Sub-Step	Item	Reported Amount	Reconciling Items	Adjusted Amount	Adjusted By	Co
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Expenses

Step	Sub-Step	Item	Reported Amount	Reconciling Items	Adjusted Amount	Adjusted By	Co
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Revenues

Step	Sub-Step	Item	Reported Amount	Reconciling Items	Adjusted Amount	Adjusted By	Co
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Expenses

Step	Sub-Step	Item	Reported Amount	Reconciling Items	Adjusted Amount	Adjusted By	Co
------	----------	------	-----------------	-------------------	-----------------	-------------	----

Revenues

Step	Sub-Step	Item	Reported Amount	Reconciling Items	Adjusted Amount	Adjusted By	Co
------	----------	------	-----------------	-------------------	-----------------	-------------	----

Summary Table

Revenue Summary	Total as Submitted	Adjustments	Total After Adjustments
Total Non-Medicaid	\$0.00	\$0.00	\$0.00
Total	\$0.00	\$0.00	\$0.00

Expense Summary	Total as Submitted	Adjustments	Total After Adjustments
Total Attendant Wages, Benefits and Mileage	\$0.00	\$0.00	\$0.00
Total Non-Attendant Wages, Benefits and Mileage	\$0.00	\$0.00	\$0.00
Total Administrative and Operations Wages, Benefits and Mileage (less Central Office)	\$1,111.00	\$0.00	\$1,111.00
Total Payroll Taxes & Workers' Compensation (Not including Central Office)	\$3.00	\$0.00	\$3.00
Total Facility and Operations Expenses (Not including Central Office)	\$0.00	\$0.00	\$0.00
Total Central Office Expenses	\$0.00	\$0.00	\$0.00
Total	\$1,114.00	\$0.00	\$1,114.00

Because this cost report indicates participation in rate enhancement in Step 4, your recoupment summary information is being provided below.

In accordance with Title 1 of the Texas Administrative Code (TAC), §355.308(s) for nursing facilities, or §355.112(t) for all other programs, the below Recoupment Summary indicates whether or not the provider is subject to recoupment for failure to meet participation requirements.

If you indicated on STEP 2 of this cost report that you requested to aggregate by program those contracts/component codes held by this Combined Entity which participated in the Attendant Compensation Rate Enhancement for the purpose of determining compliance with spending requirements, the recoupment summary information below represents the estimated total recoupment for all participating contracts/component codes on the cost reports indicated below. This same summary information is displayed on all cost reports affected by the aggregation.

Recoupment Summary

--

Program / Contract / Group	Level Awarded	Spending Requirement	Actual Spending	Per Unit Recoupment	Estimated Total Recoupment
Day Habilitation Services		\$0.00	\$0.00	\$0.00	\$100.00
Residential Services		\$0.00	\$0.00	\$0.00	\$0.00
Total Recoupment		\$0.00	\$0.00	\$0.00	\$200.00

Additional adjustments and recoupments (other than those identified above) may occur as a result of a subsequent informal review, audit, or desk review of your cost report. As per 1 TAC §355.308(s) or §355.112(t) and §355.107(a), if subsequent adjustments are made, you will be notified via e-mail to logon to STAIRS and view Step 14 of this cost report where those adjustments and any revised recoupment amount will be displayed.

Unless you request an informal review in accordance with 1 TAC §355.110, adjustments to the provider's rates per unit for this reporting period will be sent to the Health and Human Services Commission (HHSC) Provider Claims Services for processing after the "Review Period Expires" date shown above and below. Do not send checks or payments to HHSC unless specifically instructed by HHSC. The amount to be recouped will be subtracted from future billings.

PAYMENT PLANS (For Recoupments Greater Than \$25,000)

If your recoupment is greater than \$25,000 you may be eligible for a payment plan. Payment plans are not guaranteed and apply only to active contracts. If the contract terminates prior to the completion of the recoupment, any payment plan that was granted no longer applies.

- If your recoupment is for a twelve-month period and is greater than \$25,000, you may request to have it collected over the span of 3 months.
- If your recoupment is for a twelve-month period and is greater than \$75,000, you may request to have it collected over the span of 6 months.
- If the reporting period report is less than a full year with a recoupment greater \$25,000, then HHSC may approve fewer than the requested number of payments in the payment plan.

HHSC Rate Analysis Department must receive your written request for a payment plan at one of the below addresses by hand delivery, U.S. mail or special mail delivery, or email (faxes will not be accepted). A payment plan request must be received no later than the "Review Period Expires" date shown above and below. A payment plan request not received by the stated deadline will not be accepted. A payment plan request post-marked prior to the stated deadline but received after the due date will not be accepted.

This Step will not be visible until after the report has been audited and provider is notified of adjustments to or exclusions of information initially submitted. Providers will receive e-mail notification that their adjustment report is ready. Provider then has 30 days within which to review their adjustments and go to **Step 13** to Agree or Disagree with the adjustments made. After the end of that 30-day period, the report will be set to the status of Agreed by Default.

Step 13. Agree/Disagree

Disagreed by John Smith

If you disagree with an adjustment made to your Cost Report, you may request an informal review in accordance with Title 1 Texas Administrative Code (TAC) §355.110. In accordance with 1 TAC §355.110(c)(1)(A), the HHSC Rate Analysis must receive a written request for an informal review by hand delivery, United States (U.S.) Mail, or special mail delivery no later than 30 calendar days from the date of the written notification of the adjustments. Therefore, the Texas Health and Human Services Commission (HHSC) Rate Analysis Department must receive a written request no later than February 12, 2017. A request for an informal review that is not received by this deadline date will not be accepted. Requests that are post-marked prior to the deadline date but received after the deadline date will not be accepted. If you do not request an informal review by the deadline date you will not be able to request an administrative hearing regarding these exclusions or adjustments.

In accordance with 1 TAC §355.110(c)(1)(A), a 15 calendar day extension of the 30 day deadline to submit an informal review request will be granted if HHSC Rate Analysis receives a written request for the extension by hand delivery, U.S. mail, or special mail delivery no later than February 12, 2017. The extension gives the requestor a total of 45 calendar days to file the informal review request. A request for informal review or extension request that is not received by the stated deadline date will not be accepted.

The informal review request must contain:

- a concise statement of the specific actions or determinations in dispute;
- the recommended solution;
- any supporting documentation relevant to the dispute.

If the provider is disputing an adjustment, the request must:

- indicate which adjustment is in dispute;
- state what the provider believes to be the correct value; and
- contain any supporting documentation that supports these values.

It is the provider's responsibility to submit, along with the informal review request, all pertinent information listed above to support the provider's position. An informal review request that does not contain this information will not be accepted.

An informal review must be signed by an individual legally responsible for the conduct of the contracted provider, such as the sole proprietor, a partner, a corporate officer, an association officer, a governmental official, or a limited liability company member. An informal review that is not signed by an individual legally responsible for the conduct of the contracted provider will not be accepted.

The subject matter of the informal review is limited to the adjustments and exclusions made to the cost report contained in the Step 12 – Adjustment / Reconciliation / Settlement Report. In accordance with 1 TAC §355.110(d), an administrative hearing regarding exclusions and adjustments made to the cost report are limited to the decisions reached in the informal review.

The written request for an informal review must be submitted to the Director, Rate Analysis Department at the below address.

Texas Health and Human Services Commission
Rate Analysis Department, HC H-400
P.O. Box 140030
Austin, TX 78714-0030

Special Mail Delivery

Texas Health and Human Services Commission
Rate Analysis Department, HC H-400
Brown-Heathly Building
4900 N. Lamar Blvd.
Austin, TX 78751-2316

Legally responsible person

First Name:	Ray	
Last Name:	Wilsonzzz	
Job Title:	Director	
Entity Name:	ZZZ RAD IGO OPT-IN 1	
Email:	ky.wilson@hhsc.state.tx.us	
Phone (232-456-7890):	123456789	Phone Extension:
Fax (232-456-7890):	123-456-7890	Fax Extension:

Mailing Address

Street 1 or P.O. Box:	999 test
Street 2:	
City:	Austin
State:	TX
Zip (Plus 4 Optional):	75421

 Return

This Step will not be visible until after the report has been audited and provider is notified of adjustments to or exclusions of information initially submitted. The Step may only be completed by an individual legally responsible for the conduct of the contracted provider, such as the sole proprietor, a partner, a corporate officer, an association officer, a governmental official, or a limited liability company member. This individual must be designated in STAIRS with an "Entity Contact" or "Financial Contact" role.

This Step must be completed within the 30-day time frame from the date of the e-mail notifying the provider that **Steps 12 and 13** are available to the provider.

For providers with a recoupment amount above \$25,000, the option "I Agree and Request a Payment Plan" will be available during Step 13. This option finalizes the report and requests a payment plan for paying the recoupment.

If a provider's cost report has a recoupment amount below \$25,000, then the provider may still request a payment plan. The Rate Analysis Department has a formula that it uses to determine if a provider is eligible for a payment plan. However, each payment plan request will be determined on a case by case basis that considers the specific circumstances of the provider and the cost report.

Letters for a Payment Plan Request may be emailed to the Director of Rate Analysis for Long-Term Services and Supports at RAD-LTSS@hhsc.state.tx.us and must follow these requirements:

- Is on the company letterhead
- Details what is being requested (a payment plan)
- Includes the Cost Report Group number or Contract number of the report
- Includes the year and type of report (Cost Report 2018, for example)
- Is signed by the "an individual legally responsible for the conduct of the interested party, such as the sole proprietor, a partner, a corporate officer, an association officer, a governmental official, a limited liability company member, a person authorized by the applicable HHSC Enterprise or Texas Medicaid and Healthcare Partnership (TMHP) signature authority designation form for the interested party on file at the time of the request, or a legal representative for the interested party. The administrator or director of the facility or program is not authorized to sign the request unless the administrator or director holds one of these positions." Note that this is a person listed on HHSC Form 2031 and is not necessarily the entity contact in STAIRS.
- The request meets the deadline, which is 30 days from the Provider Notification date
- A provider who disagrees with an adjustment is entitled to request an informal review of those adjustments with which the provider disagrees. A provider cannot request an informal review merely by signifying provider's Disagreement in **Step 13**. The request, or a request for a 15-day extension to make the request, must be in writing and received by HHSC no later than the review period expiration date. Additionally, the request must include all necessary elements as defined in 1 TAC 355.110(c)(1):
 - A concise statement of the specific actions or determinations it disputes;
 - Recommended resolution; and
 - Any supporting documentation the interested party deems relevant to the dispute.

It is the responsibility of the interested party to render all pertinent information at the time of its request for an informal review. A request for an informal review that does not meet the requirements outlined above will not be accepted.

When a provider selects "Disagree" on Step 13, a new version of Step 13 appears with all the information necessary to file a request for an informal review.

13. Agree/Disagree

Read only view.

Last Verified by Ray Wilsonzzz on 01/05/20XX 3:48 PM

Return

Agreed and Requested a Payment Plan by Ray Wilsonzzz on 01/05/20XX 3:48 PM

PAYMENT PLANS (For Recoupments Greater Than \$25,000)

If your recoupment is greater than \$25,000 you may be eligible for a payment plan. Payment plans are not guaranteed and apply only to active contracts. If the contract terminates prior to the completion of the recoupment, any payment plan that was granted no longer applies.

- If your recoupment is for a twelve-month period and is greater than \$25,000, you may request to have it collected over the span of 3 months.
- If your recoupment is for a twelve-month period and is greater than \$75,000, you may request to have it collected over the span of 6 months.
- If the reporting period report is less than a full year with a recoupment greater \$25,000, then HHSC may approve fewer than the requested number of payments in the payment plan.

HHSC Rate Analysis Department must receive your written request for a payment plan at one of the below addresses by hand delivery, U.S. mail, special mail delivery, or email (faxes will not be accepted). A payment plan request must be received no later than the "Review Period Expires" date shown above and below. A payment plan request not received by the stated deadline will not be accepted. A payment plan request post-marked prior to the stated deadline but received after the due date will not be accepted.

A written payment plan request must be submitted to the Director for Long Term Services and Supports, Rate Analysis Department at the below address.

Texas Health and Human Services Commission
Rate Analysis Department, MC H-400
P.O. Box 149030
Austin, TX 78714-9030

Special Mail Delivery
Texas Health and Human Services Commission
Rate Analysis Department, MC H-400
Brown-Heathly Building
4900 N. Lamar Blvd.
Austin, TX 78751-2316

The written request for the informal review or extension must be signed by the Legally Responsible Party indicated in Step 13 or their Legally-authorized representative. The mailing instructions for the informal review are also included in **Step 13**.

STEP 14 HHSC INFORMAL REVIEW

14. HHSC Informal Review

Read only view.

[Return](#)

General and Statistical

Step	Sub-Step	Item	Reported Amount	Reconciling Items	Adjusted Amount	Adjusted By	Co
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Expenses

Step	Sub-Step	Item	Reported Amount	Reconciling Items	Adjusted Amount	Adjusted By	Co
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Revenues

Step	Sub-Step	Item	Reported Amount	Reconciling Items	Adjusted Amount	Adjusted By	Co
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Revenues

Step	Sub-Step	Item	Reported Amount	Reconciling Items	Adjusted Amount	Adjusted By	Co
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Summary Table

Revenue Summary	Total as Submitted	Adjustments	Total After Adjustments
Total Non-Medicaid	\$0.00	\$0.00	\$0.00
Total	\$0.00	\$0.00	\$0.00

Expense Summary	Total as Submitted	Adjustments	Total After Adjustments
Total Attendant Wages, Benefits and Mileage	\$0.00	\$0.00	\$0.00
Total Non-Attendant Wages, Benefits and Mileage	\$0.00	\$0.00	\$0.00
Total Administrative and Operations Wages, Benefits and Mileage (less Central Office)	\$1,111.00	\$0.00	\$1,111.00
Total Payroll Taxes & Workers' Compensation (Not including Central Office)	\$3.00	\$0.00	\$3.00
Total Facility and Operations Expenses (Not including Central Office)	\$0.00	\$0.00	\$0.00
Total Central Office Expenses	\$0.00	\$0.00	\$0.00
Total	\$1,114.00	\$0.00	\$1,114.00

Because this cost report indicates participation in rate enhancement in Step 4, your recoupment summary information is being provided below.

In accordance with Title 1 of the Texas Administrative Code (TAC), §355.308(s) for nursing facilities, or §355.112(t) for all other programs, the below Recoupment Summary indicates whether or not the provider is subject to recoupment for failure to meet participation requirements.

If you indicated on STEP 2 of this cost report that you requested to aggregate by program those contracts/component codes held by this Combined Entity which participated in the Attendant Compensation Rate Enhancement for the purpose of determining compliance with spending requirements, the recoupment summary information below represents the estimated total recoupment for all participating contracts/component codes on the cost reports indicated below. This same summary information is displayed on all cost reports affected by the aggregation.

Recoupment Summary

Program / Contract / Group	Level Awarded	Spending Requirement	Actual Spending	Per Unit Recoupment	Estimated Total Recoupment
Day Habilitation Services		\$0.00	\$0.00	\$0.00	\$300.00
Residential Services		\$0.00	\$0.00	\$0.00	\$0.00
Total Recoupment		\$0.00	\$0.00	\$0.00	\$600.00

Unless you request a formal appeal in accordance with 1 TAC §355.110, adjustments to the provider's rates per unit for this reporting period will be sent to the Health and Human Services Commission (HHSC), Provider Claims Services for processing 15 - 30 days after the date on the Informal Review Decision Notification Letter. Do not send checks or payments to HHSC unless specifically instructed by HHSC. The amount to be recouped will be subtracted from future billings.

PAYMENT PLANS (For Recoupments Greater Than \$25,000)

If your recoupment is greater than \$25,000 you may be eligible for a payment plan. Payment plans are not guaranteed and apply only to active contracts. If the contract terminates prior to the completion of the recoupment, any payment plan that was granted no longer applies.

- If your recoupment is for a twelve-month period and is greater than \$25,000, you may request to have it collected over the span of 3 months.
- If your recoupment is for a twelve-month period and is greater than \$75,000, you may request to have it collected over the span of 6 months.
- If the reporting period report is less than a full year with a recoupment greater \$25,000, then HHSC may approve fewer than the requested number of payments in the payment plan.

HHSC Rate Analysis Department must receive your written request for a payment plan at one of the below addresses by hand delivery, U.S. mail, special mail delivery, or email (faxes will not be accepted). A payment plan request must be received no later than the "Review Period Expires" date shown above and below. A payment plan request not received by the stated deadline will not be accepted. A payment plan request post-marked prior to the stated deadline but received after the due date will not be accepted.

A written payment plan request must be submitted to the Director for Long Term Services and Supports, Rate Analysis Department at the below address.

Texas Health and Human Services Commission
Rate Analysis Department, MC H-400
P.O. Box 149030
Austin, TX 78714-9030

Special Mail Delivery:
Texas Health and Human Services Commission
Rate Analysis Department, MC H-400
Brown-Heatly Building
4900 N. Lamar Blvd.
Austin, TX 78751-2316

Email

You may also submit a request for a payment plan to the Rate Analysis Department via email to: RAD-LTSS@hhsc.state.tx.us. The request letter must be:

- printed on the contracted provider's letterhead;
- signed by an individual legally responsible for the conduct of the contracted provider, such as the sole proprietor, a partner, a corporate officer, an association officer, a governmental official, or a limited liability company member; and
- scanned and emailed to the Rate Analysis Department using the above-referenced email address.

 Return

This Step only appears if the provider submits a request for an informal review. It is used by HHSC to make adjustments during the informal review process. Provider will not be able to access this Step until HHSC notifies provider of that adjustments are ready to be viewed.

Appendix A. Uploading Documents into STAIRS

Cost reports submitted without the required documentation will be returned to the provider as unacceptable. See 1 TAC §355.102(j)(2) and §355.105(b)(2)(B)(v).

All instructions for uploading documents into STAIRS and managing and attaching those documents electronically can be found in the STAIRS program by clicking on the Uploading File Instructions file under General Reference Materials at the bottom right hand corner of any screen in STAIRS. The Upload Center itself can be located in STAIRS on the Dashboard through clicking on Manage, to the far right on the header.

Appendix B. Allocation Methodologies

Units of Service: This allocation method can only be used for shared costs where the services have equivalent units of equivalent service and MUST be used where that is the case. An equivalent unit means the time of a service is important: a Nursing Facility (NF) and a DAHS facility both provide a "Day" of service, but one is a 24-hour "Day" while the other is not. An equivalent service means that the activities provided by staff are essentially the same.

Cost-to-Cost: If allocations based on units of service are not acceptable, and all of a provider's contracts are labor-intensive, or if all contracts have programmatic or residential building costs, the provider may choose to allocate their indirect shared costs on a cost-to-cost basis.

Salaries: If allocation based on Units of Service is not acceptable, and all of a provider's contracts are labor-intensive, or if all contracts have programmatic or residential building costs, the provider may choose to allocate their indirect shared costs on the basis of salaries. The two cost components of the salaries allocation method:

- Salaries/wages
- Contracted labor (excluding consultants)

In the cost component above, the term "salaries" does not include the following costs associated with the salaries/wages of employees:

- Payroll taxes
- Employee benefits/insurance
- Workers' compensation

Labor Costs: This allocation method can be used where all of a provider's contracts are labor intensive, or all contracts have a programmatic or residential-building cost, or contracts are mixed with some being labor intensive and others having a programmatic-building or residential-building component. It is calculated based upon the ratio of directly charged labor costs for each contract to the total directly charged labor costs for all contracts. The Five Cost Components of the Labor Costs Allocation Method:

- Salaries/Wages
- Payroll taxes
- Employee benefits/insurance
- Workers' compensation costs
- Contracted labor (excluding consultants)

Total Costs Less Facility Costs: The Total-Cost-Less-Facility-Cost allocation method can be used if a provider's contracts are mixed – some being labor-intensive and others having a programmatic or residential building component. This method can also be used for an organization that has multiple contracts all requiring a facility for service delivery. This method allocates costs based upon the ratio of each contract's total costs less that contract's facility or building costs to the provider's total costs less facility or building costs for all contracts.

If any of these allocation methods are used, the allocation summary must clearly show that all the cost components of the allocation method have been used in the allocation calculations. For example, when describing the numerator and denominator in numbers for the salaries method, the numerator and denominator each should clearly show the amount of costs for salaries/wages and for contracted labor (excluding consultants).

Square footage: This allocation method is the most reasonable for building and physical plant allocations.

Functional: If the provider has any doubt whether the functional method used is in accordance with applicable rules or requires prior written approval from the Rate Analysis

Department, send email to RAD-LTSS@hhsc.state.tx.us prior to submitting the cost report.

Time study: The time study must be in compliance with 1 TAC §355.105(b)(2)(B)(i). If the time study is not in compliance with these rules, the provider must receive written approval from HHSC Rate Analysis to use the results of the time study. According to the rules, a time study must cover, at a minimum, one randomly selected week per quarter throughout the reporting period. The allocation summary should include the dates and total hours covered by the time study, as well as a breakdown of the hours time-studied by function or business component, as applicable.

Other allocation method approved by HHSC: Requests for approval to change an allocation method or to use an allocation method other than an allocation method approved or allowed by HHSC must be received by HHSC's Rate Analysis Department before the end of the provider's fiscal year, as described at 1 TAC §355.102(j)(1)(D). To request such approval from HHSC Rate Analysis, submit and properly a disclosure statement along with justification for the change and explain how the new allocation method is in compliance with the Cost Determination Process Rules and how the new allocation method presents a more reasonable representation of actual operations.

If using an alternate allocation method, upload a properly cross-referenced copy of the provider's original allocation method approval request and any subsequent approval letter from Rate Analysis. If the provider's approval request included examples or a copy of the provider's general ledger, include those documents in the uploaded attachments for this item.

Appendix C – Reserved for Future Use