2022 Accountability Report Instructions for ICF/IID

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

For assistance with:

Report completion
Provider Finance Customer Information Center
Phone: (737) 867-7817 or Email: PFD-LTSS@hhs.texas.gov

Receipt of the report
Phone: (737) 867-7812 or Email: costinformationpfd@hhs.texas.gov

Report Groups assigned to provider's entity
Phone: (737) 867-7812 or Email: costinformationpfd@hhs.texas.gov

Report Preparers or the list of trained Preparers
Phone: (737) 867-7812 or Email: costinformationpfd@hhs.texas.gov
Adding Contacts or issues with your State of Texas Automated Information Reporting System (STAIRS) Login:
Fairbanks, LLC. Phone: (877) 354-3831 or Email: info@fairbanksllc.com

January 2022
Health and Human Services Commission

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Changes from prior reports

National Provider Identifier#:

The National Provider Identifier number (NPI) will be prepopulated here. Contact HHSC at CostinformationPFD@hhs.texas.gov if you believe this is not your current NPI.

Purpose

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

Who Must Complete this Report?

As described in Title 1 of the Texas Administrative Code (TAC) 355.112(h)(2), contracts that were participating in Rate Enhancement may be required to submit an acceptable report in certain circumstances, such as a change of ownership, contract terminations, mid-year withdrawal from the Rate Enhancement, entering participation for a partial year or other reason specified by the Health and Human Services Commission (HHSC) Provider Finance Department (PFD). Providers are notified of the requirement to submit this report in an HHSC Provider Finance letter that specifically requests this report.

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 Provider Finance 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 2022 accountability report, a preparer must attend the 2020 or 2021 Cost Report Training Webinar. Preparers without the proper training credit will not be able to access the STAIRS data entry application.

State of Texas Automated Information System (STAIRS)

STAIRS is the web-based system for long-term care HHSC Medicaid and STAR+PLUS, 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.

It is very important that the preparer read these instructions carefully.

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 2021, 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 need to contact CostInformationPFD@hhs.texas.gov. 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.

Instructions for the Cost/Accountability Reports

COVID Related Information and Updates

The Health and Human Services Commission (HHSC) Provider Finance Department (PFD) has developed the below information to provide guidance and address questions pertaining to the 2020 and 2021 Cost/2021 and 2022 Accountability Reports related to COVID-19. The following sections include guidance on COVID-19-related revenue providers may have received and instructs when to report or offset revenue against incurred expenses. Additionally, the Cost/Accountability Reports were updated to include questions designed to collect information on the initial impact of COVID-19 from providers. Those questions and instructions are below.

COVID-19 Funding Questions

CARES ACT

The Coronavirus Aid, Relief, and Economic Security (CARES) Act was passed by Congress and signed into law by President Trump on March 27th, 2020. The CARES Act provides that "…these funds may not be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse…."[i] In this case, Medicaid is considered an "Other Source" that is obligated to reimburse the expense of providing Medicaid services.

Furthermore, Title 1 of the Texas Administrative Code (TAC) §355.103(b)(18)(B), provides, "Grants and contracts from federal, state or local government, such as transportation grants, United States Department of Agriculture grants, education grants, Housing and Urban Development grants, and Community Service Block Grants, should be offset, prior to reporting on the cost report, against the particular cost or group of costs for which the grant was intended...." For purposes of the Cost/Accountability reports, the CARES Act Provider Relief Funds, the Paycheck Protection Program (PPP) and portions of the Economic Injury Disaster Loans are considered grants to the extent the funds are forgiven under the terms of the loan programs and/or the terms and conditions of the funds received.

CARES ACT - Provider Relief Funds

Qualified providers of health care, services, and support may receive Provider Relief Fund payments for healthcare-related expenses or lost revenue due to COVID-19. These distributions do not need to be repaid to the US government, assuming providers comply with the terms and conditions.

For the Cost/Accountability Reports, providers and cost report preparers should offset any PRF recognized as revenue by the provider based on increased costs due to COVID-19 not reimbursed by another source against any cost or group of costs incurred to prepare for, prevent, or respond to coronavirus otherwise recorded on the provider unadjusted trial balance prior to reporting on the actual cost report. Providers can reflect the detail of this offset in the trial balance or allocation summary uploaded as supporting documentation and report the final adjusted expenses on the cost or accountability report. An example may include, but are not limited to:

- A facility experiences an increase in expenses related to COVID-19 of $100,000. Assuming the $100,000 of additional COVID-19 related cost was paid for using PRF funds, the $100,000 would be offset against any expense incurred to prepare for, prevent, or respond to coronavirus prior to reporting on the cost report and can be reflected in the provider's trial balance or allocation summary.

PRF revenue recognized as a result of lost revenue should not reduce any expenses included on the unadjusted trial balance prior to those expenses being reported on the cost report because these lost revenue dollars are not associated with any specific expense. For Nursing Facility cost reports, this PRF revenue recognized as a result of lost revenue should instead be reported as "Gifts, Grants, Donations, Endowments and Trusts" on step 5 of the cost or accountability report as applicable and will have no impact on allowable expenses reported. For Community Care cost reports, this PRF revenue recognized as a result of lost revenue should instead be reported as "Grants and Contracts from Federal, State and Local Government Sources" on step 5 of the cost or accountability report as applicable and will have no impact on allowable expenses reported.

CARES ACT – Paycheck Protection Program

The Cares Act also established the Paycheck Protection Program (PPP). PPP funds are forgivable per the terms and conditions of the program.

For the Cost/Accountability Reports, providers and cost report preparers should offset an amount equal to any staff wages reimbursed by PPP against any otherwise incurred salary, during the cost reporting period, prior to reporting. An offset should also be made to any other non-payroll related expense for the portion of the PPP loan utilized for those non payroll items. Providers can reflect the detail of this offset in the trial balance or allocation summary uploaded as supporting documentation and report the final adjusted expenses on the cost or accountability report. An example may include, but is not limited to:

- A facility received a PPP loan in the amount of $10,000 and met the requirements for forgiveness prior to their fiscal year end. Assuming 60% of the loan amount was used for payroll related costs and 40% was used for non-payroll costs, an offset of $6,000 would occur against any department(s) otherwise incurred payroll related expenses and $4,000 would be offset against any non-payroll related expenses on the unadjusted trial balance prior to reporting the net wages on the cost or accountability report.

Rate Enhancement

Providers enrolled in the Attendant Compensation/Direct Care Compensation Rate Enhancement program receive additional funds to provide increased wages and benefits for attendants or direct care staff and must demonstrate compliance with enhanced staffing or spending requirements. Spending requirements related to rate enhancement are only applicable to paid units reported on the cost/accountability reports. TAC §§355.308(j) and 355.112(s) outlines the determination of staffing requirements for rate enhancement participants. As it relates to staffing, which is based on direct care hours, the offset of PRF and PPP revenues described above should not impact the hours reported for any department on the cost or accountability report. While the offset of some of the PRF and PPP revenues could reduce certain salaries reported on the cost report the number of hours reported should agree to the actual hours related to the unadjusted salaries because even if the salary was paid for using PRF or PPP dollars the actual hours incurred did not change and should not be reduced on the cost or accountability report. In these instances, the provider may be required to provide an explanation and should reference the PRF or PPP offset.

Local Funds

Pursuant to TAC §355.103(b)(18)(B), "Grants and contracts from federal, state or local government, such as transportation grants, United States Department of Agriculture grants, education grants, Housing and Urban Development grants, and Community Service Block Grants, should be offset, prior to reporting on the cost report, against the particular cost or group of costs for which the grant was intended....". If you have any questions about the treatment of local funds for purposes of the cost report, please contact the LTSS Center for Information and Training at PFD-LTSS@hhs.texas.gov.

Supporting Documentation

As in prior years, providers may be required to submit support documenting (e.g., trial balances, allocation summary, etc.) to support the information reported in their Cost/Accountability Report.

The state acknowledges providers may be required to submit reports to local or federal jurisdictions based on funds received (e.g. PRF, etc.) Do not provide the State with a copy of these reports and/or any applicable support documentation for these reports.

1 CARES Act, H.R. 748, 116th Cong.

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 ICF Program-Specific Rules at 1 TAC §355.456;
- The *Instructions* for completion of the report;
- The 2020 / 2021 general and program-specific Cost Report training materials.

As stated in 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 must 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 and follow 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 2020 Cost Report (if adjustment information has not been received, call (737) 867-7812;
- Have attended a Cost Report Training webinar session and received credit for the 2021 Cost Report Training sponsored by HHSC Provider Finance. 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 PFD as specified in the HHSC PFD letter requesting the AR.

All attachments as well as 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 between February 1, 2021 and December 31, 2022, 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 (737) 867-7812 before continuing with accountability report preparation. Refer to the *Instructions,* **Step 2** for additional assistance.

Website

The HHSC Provider Finance 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://pfd.hhs.texas.gov/long-term-services-supports

Failure to File an Acceptable Accountability Report

Failure to file an accountability report completed in accordance with instructions and rules by the accountability report due date 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.
1 TAC §355.105(b)(4)(C)(ii)

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 planning and organization would not have been of any assistance. HHSC Provider Finance must receive requests for extensions prior to the due date of the accountability report. The extension request must be sent to: radcostreportverification@hhsc.state.tx.us 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 accountability 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:

- Be completed in accordance with the Cost Determination Process Rules, program-specific rules, accountability report instructions, and policy clarifications
- 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 Provider Finance at costinformationpfd@hhs.texas.gov for assistance)
- Be completed using an accrual method of accounting (except for governmental entities required to operate on a cash basis)
- Be submitted online as a 2022 Accountability Report for the correct program through STAIRS
- Include any necessary supporting documentation, as required, uploaded into STAIRS
- Include signed, notarized, original certification pages (Accountability Certification and Methodology Certification) scanned and uploaded into STAIRS
- Calculate all allocation percentages to at least two decimal places (i.e., 25.75%)
- 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 via 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 as well as new certification pages 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

An interested party legally responsible for conduct of the contracted provider may initiate an amendment no later than 60 days after the original due date. Provider-initiated amendment requests can be sent to: costinformationpfd@hhs.texas.gov. Request received that is not signed by an individual legally responsible for the conduct of the contracted provider, or received after the 60th day, will not be accepted. Failure to submit the requested amendment to the accountability by the due date is considered a failure to complete an accountability report.

1 TAC §355.105(d)(1)(A)

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 Provider Finance.

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. The contracted provider must review all reported data as well as the Methodology Certification, therefore the Entity Certification page may not be signed prior to the Methodology Certification page.

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 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 Provider Finance. 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 accountability 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 accountability 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 accountability 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 accountability 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 accountability 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 accountability 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, facility lease, 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 §49.307 (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 seven years after all issues that arise from any litigation, claim, negotiation, audit, open records request, administrative review, or other action involving the records are resolved.

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 within ten (10) working days of the request or a later date as specified by HHSC. 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 Provider Finance 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

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 data 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.

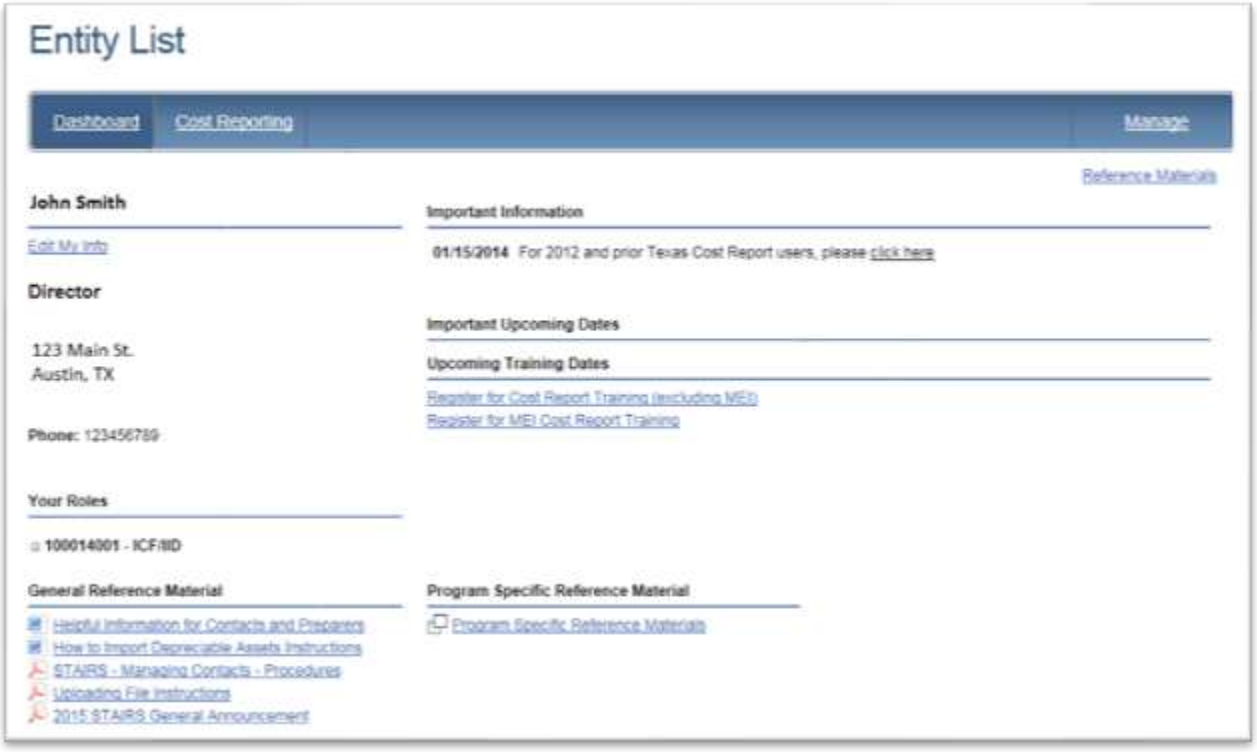
Save: Used to save the current data. This will save the information in the current location and allow additional Add, Edit or Delete actions.

Save and Return: This 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 accountability report. They inform 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



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. Important information messages, listings of important dates, and upcoming training opportunities are included on the Dashboard page. 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. This is also where contact information is kept updated. It is imperative to maintain correct / current contact information in order to receive necessary automated messages and deadlines regarding reports/contracts.

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.

Step 1. Combined Entity Identification

Purpose

The purpose of this section is to gather contact information so that HHSC PFD can contact provider/preparer/etc. during the review of the cost report. It is important to verify that all contact information is correct to ensure that provider receives all review correspondence. Step 1 fields will either be auto populated for subsequent reports (from the prior entities' cost/accountability report) or blank (if this is the first report for an entity).

How HHSC PFD uses the information?

This information is used by the HHSC PFD to obtain information and documentation needed to address issues found in the cost report review. We contact preparers and providers on a regular basis.

In order to receive notices for report deadlines, notices of reports not received by the deadline including vendor hold warnings and notices, notification to providers of adjustments made to their report since certification and recoupments. Please ensure your email address is correct in the Edit My Info link found when first logging into STAIRS on the Dashboard.

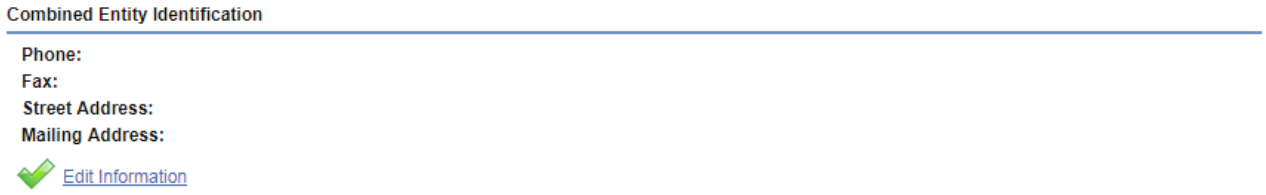
It is vital the preparer and certifier reviews, updates/enters and verifies the current information for the applicable contacts, as defined below, to ensure timely notifications.

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.

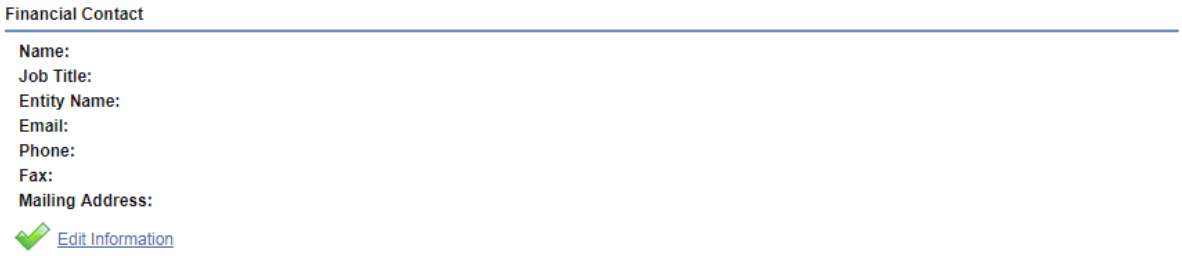
Entity Contact Identification

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 Identification

A primary contact may designate a Financial Contact. This person can review the accountability report but may not make entries into the system. The Financial Contact must be an employee of the controlling entity, parent company, sole member, governmental body, or related-party management company, an external contracted preparer may not be listed as a provider's Financial Contact.



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 Provider Finance 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 a cost and/or an accountability report is submitted. Such training is required every other year for the odd-year cost and/or accountability report in order for the preparer to be qualified to complete both that odd-year cost report and the following even-year cost and or accountability report. To sign as preparer of a 2022 accountability report for a specific program, the preparer must have attended and received credit for the appropriate 2020 or 2021 Report.

Cost and/or Accountability report preparers may be employees of the provider or persons who have been contracted by the provider for the purpose of cost and/or accountability report preparation. Outside preparers may not be listed as either Entity or Financial contacts. 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 accountability 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

Purpose

The purpose of step to is to give general information, including the Combined Entity's reporting period and to determine if the Combined Entity wants to aggregate reporting expenses used to determine compliance in the Rate Enhancement program.

How HHSC PFD uses the information?

If the provider chooses to aggregate their contracts by the program that participates in the Attendant Compensation Rate Enhancement program, then HHSC PFD will use combined expenses to determine compliance with spending requirements.

What does it mean to aggregate your reports?

Aggregate - For a combined entity that controls two or more commonly owned contracts in a program to determine compliance with the spending requirement.

If your aggregating reports' expenses

When we combine expense from multiple reports of the same program for determining the combined entity's compliance in the rate enhancement program.

How do you know if you should aggregate?

- You must have two or more reports in the same cost reporting entity.
- You must have two or more contracts in the same program.
- All contracts within the same entity and program are participants in rate enhancement.
- Contracts that are terminating are not eligible for aggregation.

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 an accountability 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 accountability report year. If these dates are not correct, contact HHSC Provider Finance at costinformationpfd@hhs.texas.gov for assistance. Failure to assure that the reporting period is correctly identified will result in the accountability 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 Provider Finance 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

Purpose

The purpose of this step is to collect information about the combined entity's business components.

Step 3.a. details the combined entity's Medicaid fee-for-service contracts or STAR+PLUS contracts.

Step 3.b. details the combined entity's other contracts with the state of Texas, excluding contracts in Step 3. a.

Step 3.c. details all other business components or contracts not listed in Steps 3.a. or 3.b.

How HHSC PFD uses the information

HHSC PFD uses the information in Step 3 during the Cost or Accountability report examination process. Financial examiners will ensure that only your expenses associated with the component under the appropriate Medicaid contract are reported on your Cost or Accountability Report.

How to complete Step 3

Step 3.a. Verify Contracts for Requested Reports

This list carries over from year to year. It is a list of all IID 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 Provider Finance at costinformationpfd@hhs.texas.gov 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 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)

This is a list of all Texas and out-of-state business relationships in which the combined entity is involved not already listed in Step 3.a. and must include all other contracts (i.e.: Medicare, CACFP, Hospice etc).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 accountability report 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 accountability report(s) for any other component code(s) controlled by the provider's combined entity. If another preparer has verified steps involving allocation, then completed steps will need to be verified again. The other preparer will need to address those steps again prior to completing those reports.

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.

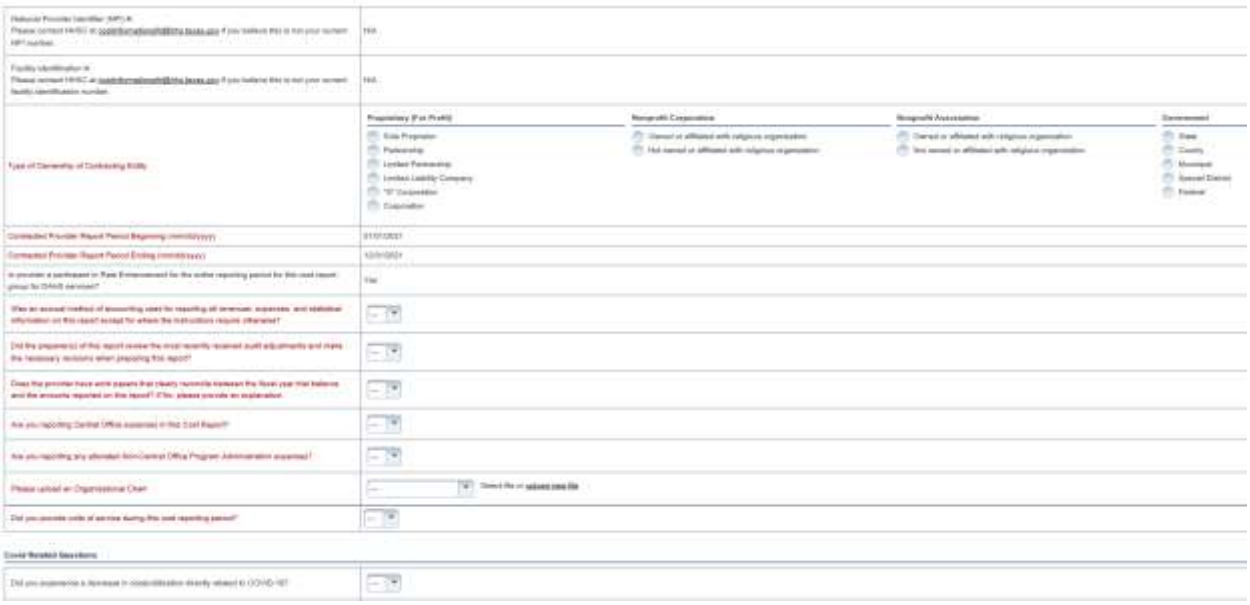
To Edit or Delete a contract, select it by clicking the round button to the far left beside that contract. Then choose an action, either Edit Record or Delete Record.

Step 3.c. Verify Business Component Summary

This screen lists all component codes, contracts, grants and business entities contained in **Steps 3.a. and 3.b.** 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 3.b.** above.

Step 4. General Information

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



National Provider Identifier#:

The National Provider Identifier number (NPI) will be prepopulated here. Contact HHSC at Costinformationpfd@hhs.texas.gov if you believe this is not your current NPI.

Facility Identification #:*

The Facility Identification Number is prepopulated. Please contact HHSC at CostInformationpfd@hhs.texas.gov if you believe this is not your current facility identification number.

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 Provider Finance at costinformationpfd@hhs.texas.gov 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 2022:

In situations where the component code did not have at least one contract active for the provider's entire fiscal year ending in 2022, 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 2022, 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 2022, 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 2022 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 2022 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 2021 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 Provider Finance 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 Provider Finance at costinformationpfd@hhs.texas.gov.

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 Provider Finance at costinformationpfd@hhs.texas.gov.

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?

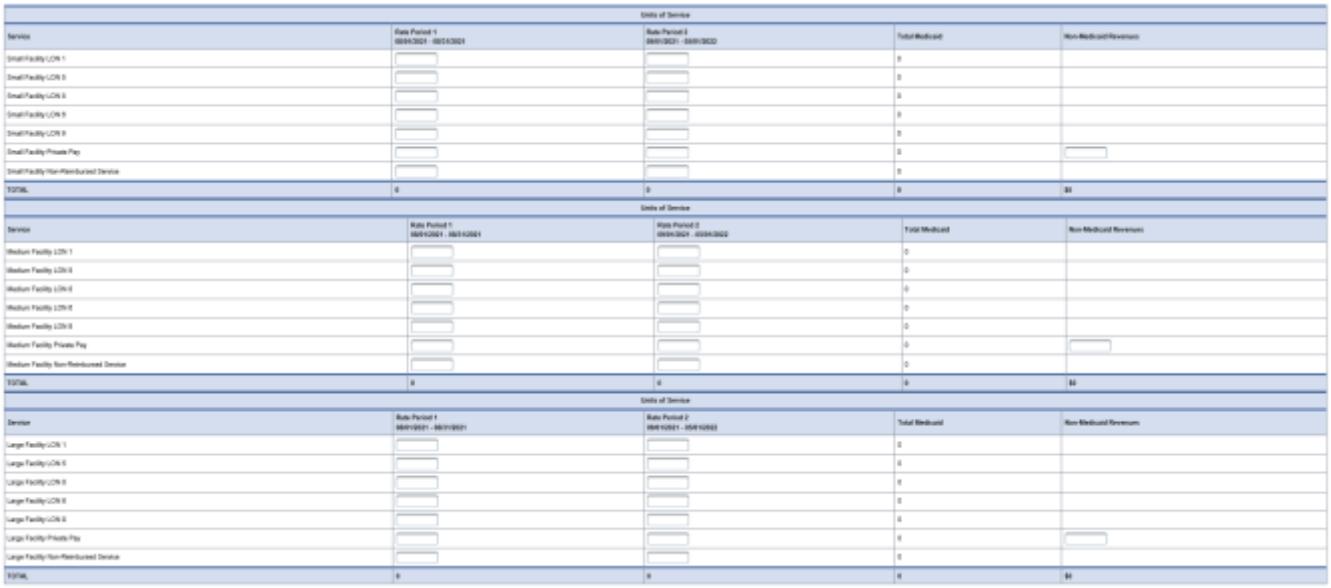
Click either "Yes" or "No". When provider clicks "Yes", then the workpapers must be uploaded to the report. There should not be situations where providers respond to this question with "no". Each provider must maintain reconciliation work papers and any additional supporting work papers (such as invoices, 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).

Did you provide Units of Service during this cost reporting period?

Click either "Yes" or "No". When a provider clicks "No", You may be eligible for a cost report excusal. If you have provided any services during the reporting period, change

the answer to “Yes”. If not, please contact the Provider Finance Department at costinformationpfd@hhs.texas.gov.

Step 5. Days of Service and Revenue Entry



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.

Private Pay

Report any units of service and revenue for DAHS services that were paid by another payer source. This can include private pay and private insurance. Do not report: Veterans Administration and Qualified Medicare Beneficiary (QMB), STAR Kids, Medically Dependent Children's Program (MDCP), Personal Care Services (PCS) or other forms of Medicaid services. Do not include Medicare or federal government services or other business components not listed.

Non-Reimbursed Service

Report any units where an individual received services, but the unit was not reimbursed by any payer source. This can include individuals served who lost Medicaid eligibility that were not reimbursed and thus there is no associated revenue at the time.

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

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

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"*

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.

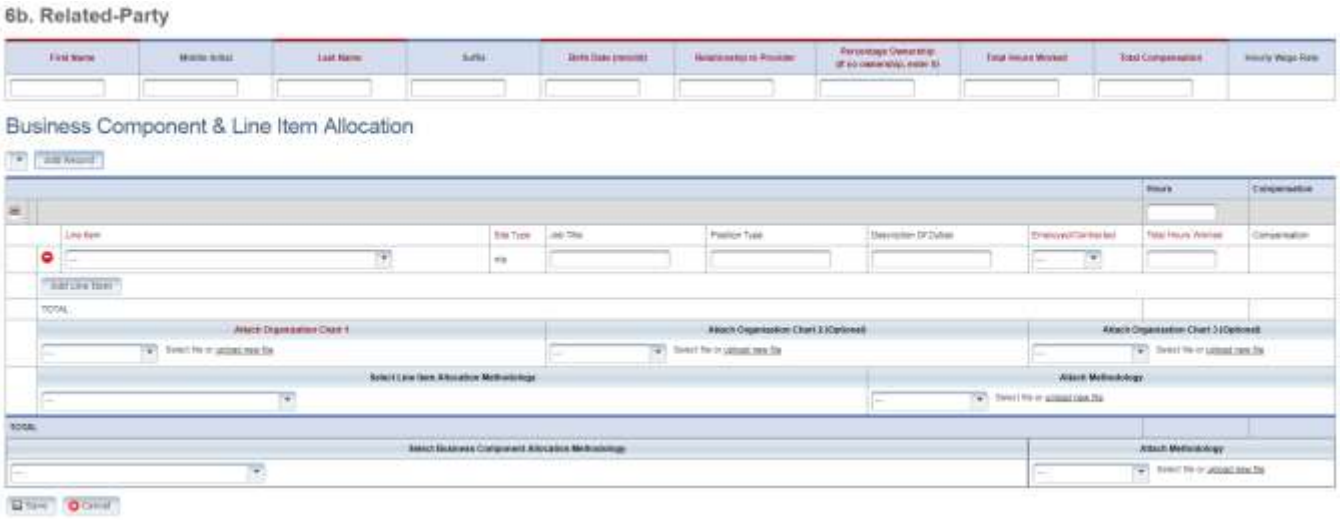
J. Hourly Wage Rate – Calculated figure based on Total Compensation divided by Total Hours Worked.

   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.

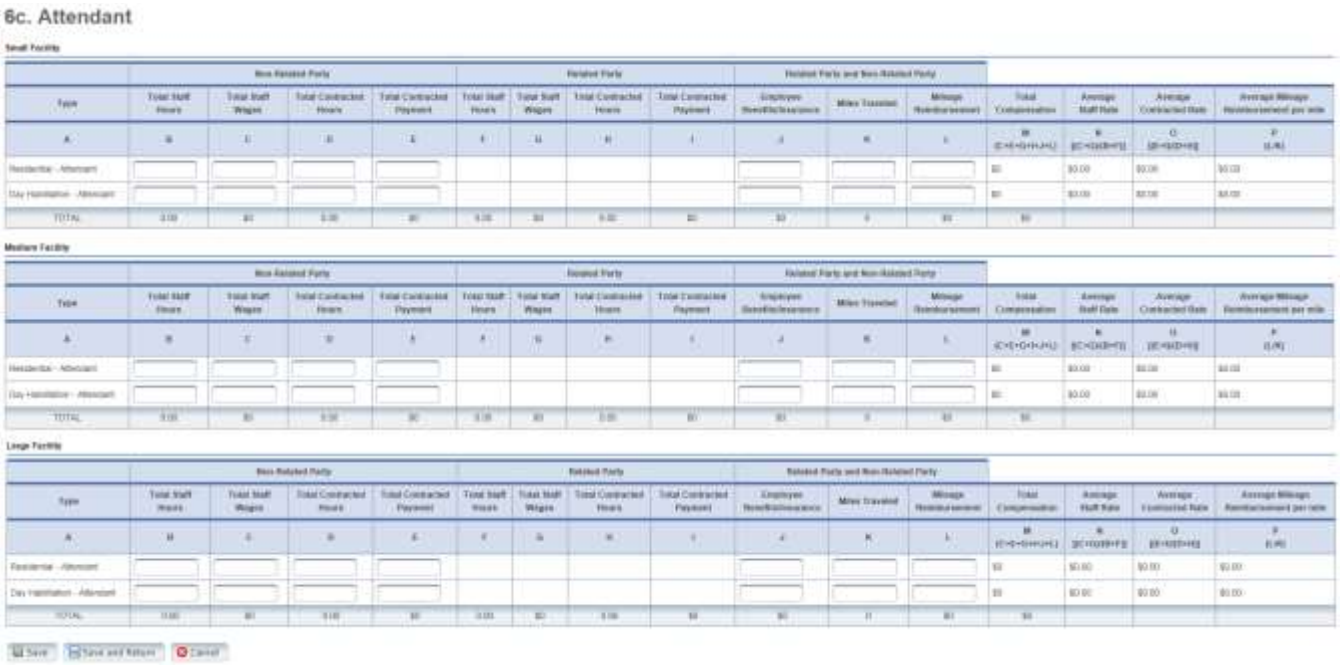
A. Business Component – The drop-down menu includes all business components for the provider entity. If provider entity only has one business component, the drop-down menu does not appear, and the single business component is automatically entered under business component.
B. Click "Add Record" – Generates 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.



A. Hours – On the grey bar, enter hours allocated or direct costed to each business component. Compensation amount will be automatically calculated.
B. Line Item – The drop-down menu includes all staff types reportable in this Accountability 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.
C. Job Title – Related Party's title within the specific business component

D. 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.
E. Description of Duties – Provide a description of the duties performed by the related individual as they relate to the specific accountability 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. The organizational chart must include both name and position of each related party.
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



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 6.b.** 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 include 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 include 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:

- 1/1/20 – 12/31/20 57.5 cents per mile
- 1/1/21 – 12/31/21 56.0 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

Purpose

The purpose of Step 7 is to collect Payroll Taxes and Workers' Compensation information for the contracted provider's attendant, non-attendant, administrative and central office staff.

How do we use this information?

HHSC PFD uses this information to determine the contracted provider's Payroll Taxes and Workers' Compensation expenses. Expenses are used in the report reconciliation process to determine spending compliance in the Rate Enhancement program and rate-setting calculations.

How to complete Step 7

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.

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".

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 more than the FICA Wage Limit ($147,000 for 2022), 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 Accountability 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 Accountability 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 Accountability 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). ***Appendix E.***

Step 9. Online Verification and Submission

Purpose

The summary verification table shows the Total Reported Revenues and Total Reported Expenses entered into STAIRS. This step allows the provider to reconcile the Trial Balance and associated work papers.

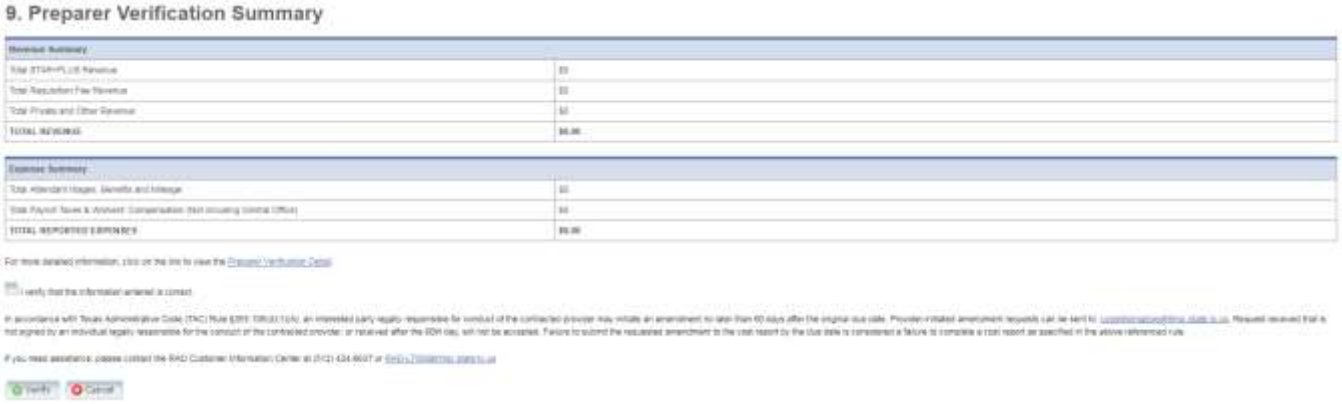
How do we use this information?

This information is made available for verification purposes only. HHSC does not use this information.

How to complete Step 9

Preparer Verification Summary

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 and that all appropriate documentation has been uploaded, 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

Purpose

Providers must certify the accuracy of cost reports submitted to HHSC. Providers may be liable for civil and/or criminal penalties if the cost report is not completed according to HHSC requirements or is determined to contain misrepresented or falsified information. Cost report preparers must certify that they have read the cost determination process rules, the reimbursement methodology rules, the cost report cover letter and cost report instructions, and that they understand that the cost report must be prepared in accordance with the cost determination process rules, the reimbursement methodology rules and cost report instructions.

A person with supervisory authority over the preparation of the cost report who reviewed the completed cost report may sign a certification page in addition to the actual preparer.

Per 1 TAC §355.105(b)(3).

How do we use this information?

HHSC uses this information to ensure that the report has been verified by the entity and preparer as per TAC rules.

How to complete Step 10 and 11

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 accountability report is completed and locked. If it is discovered that additional changes need to be made, the preparer must contact costinformationpfd@hhs.texas.gov 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 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.

Preparer (Methodology) Certification

This page must be signed by the person identified in **Step 1** of this accountability report as *Preparer.* This person must be the individual who actually prepared the accountability report or who has primary responsibility for the preparation of the accountability report for the provider. Signing as *Preparer* carries the responsibility for an accurate and complete accountability 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 accountability 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 Accountability report. Ultimate responsibility for the accountability report lies with the person signing as *Preparer.* If more than one person prepared the Accountability 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.

Step 10. Preparer Cretification

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

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

Step 11. 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.

Step 12. Provider Adjustment Report

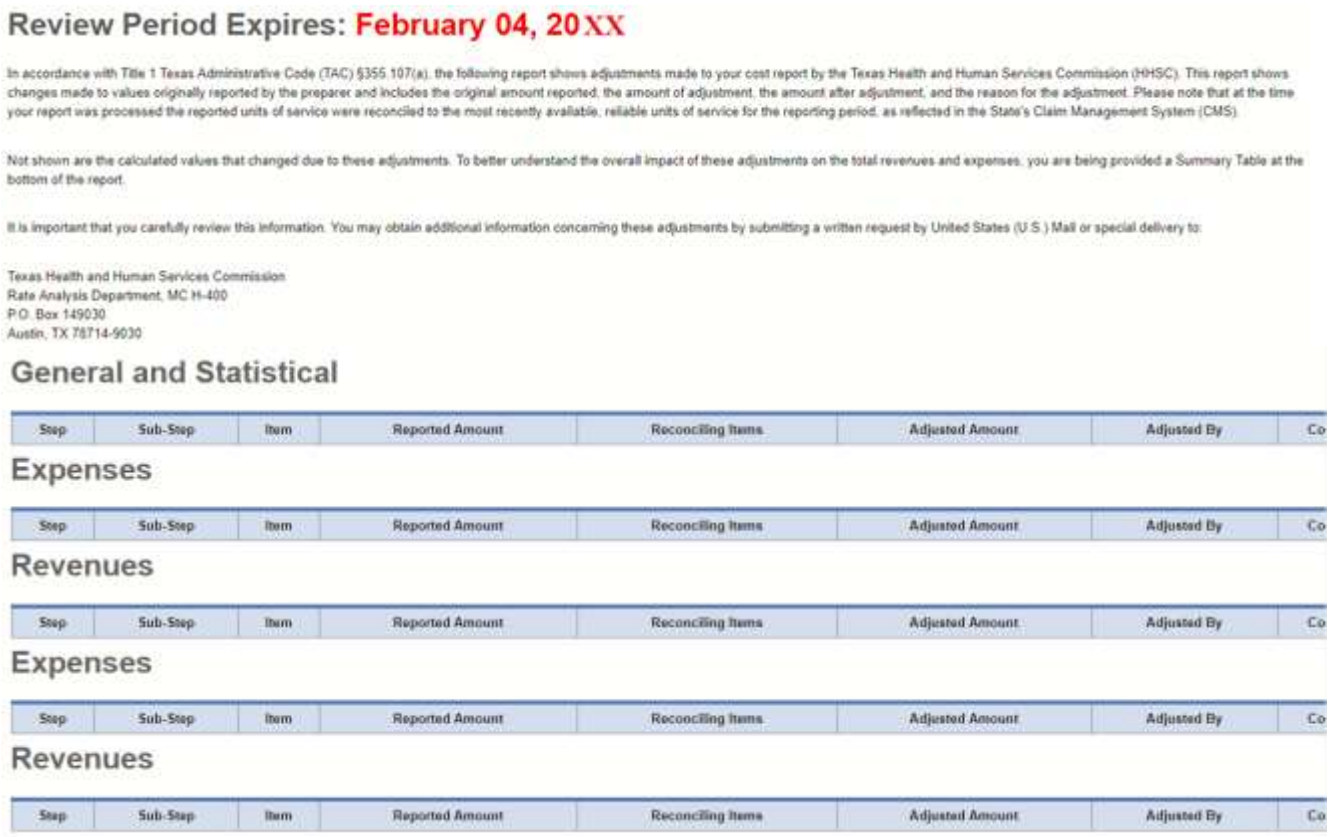
Purpose

The purpose is for the provider to review the report adjustments made during HHSC's financial examination.

The Provider has 30 days to review their adjustments. This is an opportunity to review and make a determination for a informal review in Step 13 or agree with the adjustment.

How to complete Step 12

This Step will not be visible until after the report has been reviewed 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 to review their adjustments, this entails clicking on step 12 and reviewing the adjustment report. Once you review Step 12 then Step 13 will be available 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.



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

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

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.

Step 13. Agree/Disagree

Purpose

The purpose of this step is for the provider to request an informal review, or agree with adjustments.

How do we use this information?

HHSC uses this information to start the informal review process, or set the report to complete.

How to complete Step 13

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.


13. Agree/Disagree

Agreed and Requested a Payment Plan by John Smith

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.

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 accountability report has a recoupment amount below $25,000, then the provider may still request a payment plan. The Provider Finance 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 Provider Finance for Long-Term Services and Supports at PFD-LTSS@hhs.texas.gov 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 2022, 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.

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

General and Statistical

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

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

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(l) 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

Accountability 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 based on salaries. The two cost components of the salary's 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 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 salary's 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 Provider Finance Department, send email to PFD-LTSS@hhs.texas.gov prior to submitting the Accountability 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 Provider Finance 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 Provider Finance 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 Provider Finance, submit to PFD-LTSS@hhs.texas.gov 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 Provider Finance. 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

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)

Administration Costs - The share of allowable expenses necessary for the general overall operation of the contracted provider's business that is either directly chargeable or properly allocable to this program. Administration costs include office costs and central office costs (i.e., shared administrative costs properly allocated to this program), if applicable. Administration costs are not direct care costs.

Aggregate - formed or calculated by the combination of many separate units or items; total. "the aggregate amount of grants made"

Allocation - A method of distributing costs on a pro rata basis. For more information, see Cost Allocation Methods in the General Instructions section and the 2021 Cost Report Training materials.

1 TAC §355.102(j)

Allowable Costs - Expenses that are reasonable and necessary to provide care to Medicaid recipients and are consistent with federal and state laws and regulations.

1 TAC §355.102(a) and §355.103(a)

Amortization - The periodic reduction of the value of an intangible asset over its useful life or the recovery of the intangible asset's cost over the useful life of the asset. May include amortization of deferred financing charges on the financing or refinancing of the purchase of the building, building improvements, building fixed equipment, leasehold improvements and/or land improvements. The amortization of goodwill is an unallowable cost. The amortization of the purchase price of a Medicaid contract itself (as opposed to the purchase price of the physical facility) is an unallowable cost. For additional information, see instructions for **Step 8.e.**

1 TAC §355.103(b)(7)

Applied Income - The portion of the daily payment rate paid by the individual in residential programs. Texas Health and Human Services Commission (HHSC) determines how much the individual is to pay.

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

Attendants do not include the director, administrator, assistant director, assistant administrator, clerical and secretarial staff, professional staff, other administrative staff, licensed staff, attendant supervisors, or maintenance staff. See the TAC reference for additional details and exceptions.

1 TAC §355.112(b)

Bad Debt - Unrecoverable revenues due to uncollectible accounts receivable. Bad debts are not reported on the Medicaid cost report.

1 TAC §355.103(b)(20)(M)

Building (Facility) Costs - Costs to be reported as Facility Costs. When allocating shared administrative costs (central office costs) based upon the total-cost-less-facility-cost allocation method, the building (facility) costs to be removed from the cost calculation include Lease/Rental of Building/Facility/Building Equipment; Insurance for those items; Utilities, Maintenance and Contract Services of those items; Mortgage Interest; Ad Valorem Taxes; and Depreciation for Building/Facility/Building Equipment/Land/Leasehold Improvements. Building costs must exclude any goodwill (see definition for *Goodwill*).

Business Component - A separate business entity; a state contract, program, or grant; or an operation separate from the contracted provider's contract that makes up part of the total group of entities related by common ownership or control (i.e., one part of the entire related organization such as Medicare, CACFP, etc.). Each separate contract with the state of Texas is usually considered a separate business component / entity. For the IID programs, each component code within a program is considered a separate business component. See also Central Office.

Central Office - Any contracted provider who provides administrative services shared by two or more business components is considered to have a central office. For cost-reporting purposes, a "central office" exists if there are shared administrative functions that require allocation across more than one business. Central office costs are also known as allocated shared administrative costs. The shared administrative functions could be provided by a separate corporation or partnership, or they could be a separate department or separate accounting entity within the contracted entity accounting system. The shared administrative functions could be provided in their own building or co-located with one of the entities for which they provide administrative services (e.g., the shared administrative functions could be provided from spare office space within a programmatic location).

If an organization consists of two or more contracted entities/business components/service delivery programs that are owned, leased or controlled through any arrangement by the same business entity, that organization probably has administrative costs that benefit more than one of the contracted entities/business components/service delivery programs, requiring that the shared administrative costs be properly allocated across the contracted entities/business components/service delivery programs benefiting from those administrative costs. Typical shared administrative costs may include costs related to the chief executive officer (CEO), chief financial officer (CFO), payroll department, personnel department and any other administrative function that benefits more than one business component. See also the Instructions for Central Office.

1 TAC §355.103(b)(7)

Chain - Contracted entities/business components/service delivery programs that have a common owner or sole member or are managed by a related-party management company are considered a chain. A chain may also include business organizations which are engaged in activities other than the provision of the Medicaid program services in the state of Texas. This means that the business components could:

- Be located within or outside of Texas;
- Provide services other than the Medicaid services covered by this cost report, and
- Provide services which may or may not be delivered through contracts with the state of Texas.

Charity Allowance - A reduction in normal charges due to the indigence of the resident/participant. This allowance is not a cost since the costs of the services rendered are already included in the contracted provider's costs.

Combined Entity - one or more commonly owned corporations and/or one or more limited partnerships where the general partner is controlled by the same identical persons as the commonly owned corporation(s). May involve an additional Controlling Entity which owns all members of the combined entity.

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 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)

Compensation of Employees - Compensation includes both cash and non-cash forms of compensation subject to federal payroll tax regulations. Compensation includes wages and salaries (including bonuses); payroll taxes and insurance; and benefits. Payroll taxes and insurance include Federal Insurance Contributions Act (old age, survivors, and disability insurance (OASDI) and Medicare hospital insurance); Unemployment Compensation Insurance; and Workers' Compensation Insurance.

1 TAC §355.103(b)(1)

Compensation of Owners and Related Parties - Compensation includes both cash and non-cash forms of compensation subject to federal payroll tax regulations. Compensation includes withdrawals from an owner's capital account; wages and salaries (including bonuses); payroll taxes and insurance; and benefits. Payroll taxes and insurance include Federal Insurance Contributions Act (old age, survivors, and disability insurance (OASDI) and Medicare hospital insurance); Unemployment Compensation Insurance; and Workers' Compensation Insurance. Compensation must be made in regular periodic payments, must be subject to payroll or self-employment taxes, and must be verifiable by adequate documentation maintained by the contracted provider.

1 TAC §355.103(b)(2)

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 Management - See definition for *Management Services*

Contracted Beds - Not applicable for the DAHS Cost Report

Contracted Provider See definition for *Provider*

Contracted Staff - See definition for *Contract Labor*

Contracting Entity - The business component with which Medicaid contracts for the provision of the Medicaid services included on this cost report. See Instructions for **Step 4.**

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 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.

Courtesy Allowance - A reduction in normal charges granted as a courtesy to certain individuals, such as physicians or clergy. This allowance is not a cost since the costs of the services rendered are already included in the contracted provider's costs.

Cost Report Group Code - The number used to identify an individual cost report. HHSC PFD will group one or more DAHS contracts for each legal entity into a DAHS Cost Report(s) depending on rate enhancement participation level (if applicable), cost reporting period and other factors, and will assign the Cost Report Group Code

DAHS Cost Report – A single cost report that will collect cost data for the DAHS program.

Depreciation Expense - The periodic reduction of the value of an asset over its useful life or the recovery of the asset's cost over the useful life of the asset. For additional information, see Instructions for **Step 8.e.**

1 TAC §355.103(b)(10)

Direct Care - Care provided by provider personnel (i.e., Attendants, RNs, LVNs and Therapists) in order to directly carry out the individual plan of care.

Direct Cost - An allowable expense incurred by the provider specifically designed to provide services for this program. If a general ledger account contains costs (including expenses paid with federal funds) attributable to more than one program, the individual entries to that general ledger account which can be specifically "charged" to a program should be charged to that program (i.e., direct costed or directly charged). Those general ledger entries that are shared by one or more programs should be properly allocated between those programs benefited. If an employee performs direct care services for more than one program area (or organization or business component), it will be necessary to direct cost (i.e., directly charge) that employee's costs between programs based upon actual timesheets rather than using an allocation method. If an employee performs both direct care services and administrative services within one or more organizations/business components, it will be necessary to document the portion of that employee's costs applicable to the delivery of direct care services based upon daily timesheets; time studies are not an acceptable method for documenting direct care employees' costs. Direct costs include both salary-related costs (i.e., salaries, payroll taxes, employee benefits, and workers' compensation costs) and non-labor costs such as the employee's office space costs (e.g., facility costs related to the square footage occupied by the employee's work area) and departmental equipment (e.g., computer, desk, chair, bookcase) used by the employee in the performance of the employee's duties. See definition for *Direct Costing*.

Direct Costing - A method of assigning costs specifically to particular units, divisions, cost centers, departments, business components, or service delivery programs for which the expense was incurred. Costs incurred for a specific entity must be charged to that entity. Costs that must be direct costed include health insurance premiums, life insurance premiums, other employee benefits (e.g., employer-paid disability insurance, employer-paid retirement contributions, and employer-operated child day care for children of employees), and direct care staff salaries and wages. See definition for *Direct Cost*.

Facility Costs - See definition of *Building Costs.*

Goodwill - The value of the intangible assets of a business, especially as part of its purchase price. Goodwill is not an allowable cost on the cost report. See instructions for **Step 8** for instructions on the removal of goodwill.

Legend Drug (prescription drug) - Any drug that requires an order from a practitioner (e.g., physician, dentist, nurse practitioner) before it may be dispensed by a pharmacist, or any drug that may be delivered to a resident by a practitioner during the practitioner's practice.

Management Services - Services provided under contract between the contracted provider and a person or organization to provide for the operation of the contracted provider, including administration, staffing, maintenance, or delivery of resident/participant care services. Management services do not include contracts solely for maintenance, laundry, or food service. If the provider contracts with another entity for the management or operation of the program, the provider must report the specific direct services costs of that entity and not the amount for which the provider is contracting for the entity's services. Expenses for management provided by the contracted provider's central office must be reported as central office costs.

1 TAC §355.103(b)(6) and 1 TAC §355.457(b)(2)(A)

Medicaid-only Resident/Participant – Residents/participants who are eligible recipients of Medicaid vendor payments and who ARE NOT ELIGIBLE for payments for ancillary services from other sources (such as Medicare or private insurance).

Necessary - Refers to the relationship of the cost, direct or indirect, incurred by a provider to the provision of contracted care. Necessary costs are direct and indirect costs that are appropriate in developing and maintaining the required standard of operation for providing care for individuals in accordance with the contract and state and federal regulations. See TAC reference for additional requirements.

1 TAC 355.102(f)(2)

Net Expenses - Gross expenses less any purchase discounts or returns and purchase allowances. Only net expenses should be reported on the cost report.

1 TAC §355.102(k) and 1 TAC §355.103(b)(18)(D)

Non-Medicaid Residents/Participants - Non-Medicaid residents /participants include, but are not limited to, private pay, private insurance.

Non-Reimbursed Service

Report any units where an individual received services, but the unit was not reimbursed by any payer source. This can include individuals served who lost Medicaid eligibility that were not reimbursed and thus there is no associated revenue at the time.

Owner - An individual (or individuals) or organization that possesses ownership or equity in the contracted provider organization or the supplying organization. A person who is a sole proprietor, partner, or corporate stockholder-employee owning any of the outstanding stock of the contracted provider is considered an owner, regardless of the percentage of ownership.

1 TAC §355.102(i)(2)) and 1 TAC §355.103(b)(2)(A)(i)

Private Pay

Report any units of service and revenue for DAHS services that were paid by another payer source. This can include private pay and private insurance. Do not report: Veterans Administration and Qualified Medicare Beneficiary (QMB), STAR Kids, Medically Dependent Children's Program (MDCP), Personal Care Services (PCS) or other forms of Medicaid services. Do not include Medicare or federal government services or other business components not listed.

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 cost report. Also known as contracted provider. See definitions for *Component Code, Contracting Entity*, and *Cost Report Group.*

Purchase Discounts - Discounts such as reductions in purchase prices resulting from prompt payment or quantity purchases, including trade, quantity, and cash discount result from the type of purchaser the contracted provider is (i.e., consumer, retailer, or wholesaler). Quantity discounts result from quantity purchasing. Cash discounts are reductions in purchase prices resulting from prompt payment. Reported costs must be reduced by these discounts prior to being reported on the accountability report.

1 TAC §355.102(k)

Purchase Returns and Allowances - Reductions in expenses resulting from returned merchandise or merchandise that is damaged, lost, or incorrectly billed. Expenses must be reduced by these returns and allowances prior to being reported on the cost report.

1 TAC §355.102(k)

Reasonable - Refers to the amount expended. The test of reasonableness includes the expectation that the provider seeks to minimize costs and that the amount expended

does not exceed what a prudent and cost-conscious buyer pays for a given item or service. See TAC reference for additional considerations in determining reasonableness.

1 TAC 355.102(f)(1)

Refunds and Allowances - Reductions in revenue resulting from overcharges.

Reimbursement Methodology for DAHS - Rules by which HHSC determines daily payment rates for DAHS services that are statewide and uniform by class of service and level of need.

1 TAC §355.6907

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. **Step 6** and **Step 8** of STAIRS both have sub steps designed for reporting compensation of related parties (both wage and contract compensation) and related-party transactions, including the purchase/lease of equipment, facilities, or supplies, and the purchase of services including related-party loans (i.e., lending services). 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)

Resident - Any individual residing in a residential Medicaid program facility.

Resident Day - Services for one resident for one day. The day the resident is admitted is counted as a day of service. The day the resident is discharged is not counted as a day of service. A resident day is also known as a day of service and is the unit of service for a residential Medicaid program.

Revenue Refunds - Reductions in revenue resulting from overcharges.

Safety Program - An ongoing, well-defined program for the reduction/prevention of employee injuries. The costs to administer such a program may include the development/purchase and maintenance of a training program and safety officer/consultant costs. Salaries and wages for staff administering the safety program must be based upon the hours worked on the safety program (from actual timesheets or time studies). These safety program costs should be reported as Administration Costs.

Self-insurance – See **Appendix E.**

1 TAC §355.103(b)(13)(B)

Startup Costs - Those reasonable and necessary preparation costs incurred by a provider in the period of developing the provider's ability to deliver services. Startup costs can be incurred prior to the beginning of a newly formed business and/or prior to the beginning of a new contract or program for an existing business. Allowable startup costs include, but are not limited to, employee salaries, utilities, rent, insurance, employee training costs, and any other allowable costs incident to the startup period. Startup costs do not include capital purchases, which are purchased assets meeting the criteria for depreciation as described in the Cost Determination Process Rules. Any costs that are properly identifiable as organization costs or construction costs must be appropriately classified as such and excluded from startup costs. Allowable startup costs should be amortized over a period of not less than 60 consecutive months. If the business component or corporation never commences actual operations, or if the new contract/program never delivers services, the startup costs are unallowable.

1 TAC §355.103(b)(20)(D)

Vendor Hold - HHSC rules specify that Medicaid payments from HHSC may be withheld from contracted providers in certain specific situations, as described in 1 TAC §355.111.

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.*