2022 Accountability Report Instructions for NF

Nursing Facility

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

February 2022
Texas Health and Human Services Commission

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Changes from prior reports

National Provider Identifier (NPI) – Step 4

The NPI Number is uploaded by HHSC PFD. This number is the standard unique health identifier for health care providers.

State of Texas Automated Information System (STAIRS)

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

Login IDs and passwords do not change year-to-year. The provider's designated Primary Entity Contact can access STAIRS via the links given in the email notifying them of their login ID and password. If the provider is new for 2022, 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.

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 an accountability 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 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.

Purpose of an Accountability Report

The purpose of a Medicaid Accountability Report is to gather financial and statistical information for HHSC to use in the determination of accountability under the Direct Care Staff 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.

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.

Temporary COVID-19 Add-On Rate Increases for Nursing Facilities and certain HCS Providers

Nursing Facility (NF) and certain HCS providers received a temporary COVID-19 rate add-on effective April 1, 2020, that will conclude no later than the end of the federally-declared public health emergency (PHE).

The payment rate add-ons for the HCS waiver only apply to providers delivering in-home day habilitation services to persons with intellectual disabilities or related conditions residing in three or four-bed group homes and receiving Supervised Living or Residential Support Services. These rate increases will apply to the current day habilitation rates so that providers delivering services in group homes can maintain hourly direct care staff wages due to reduced client to staff ratios. NF providers may utilize the additional funding for COVID-related expenses, including direct care staff salary and wages, PPE, and dietary needs/supplies.

The costs compensated with these funds should be included on the cost report in the applicable section(s) and not be reduced by the amount of the temporary rate increase earned.

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 Title 1 of the Texas Administrative Code (TAC) §§355.101-355.110;
- Nursing Facility (NF) program-specific rules at 1 TAC §355.306-355.308 and 355.403;
- 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 Accountability Reports. Except as otherwise specified in HHSC's Cost Determination Process Rules, accountability 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.

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. The most recently received adjustments are likely those for the 2020 Cost Report (if adjustment information has not been received, call (737) 867-7812;
- First time preparers must attend an Initial Cost Report Training Webinar session and receive credit for the 2021 Cost Report Training sponsored by HHSC. Preparers without the proper 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 Provider Finance Department as specified in the HHSC Provider Finance 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 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 report preparation. Refer to the *Instructions,* **Step 2** for additional assistance.

Website

The HHSC Provider Finance website contains program specific accountability 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: costinformationpfd@hhs.texas.gov 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.

1 TAC §355.105(c)(3)

Standards for an Acceptable Accountability Report

To be acceptable, an accountability report must:

1. Be completed in accordance with the Cost Determination Process Rules, program-specific rules, accountability report instructions, and policy clarifications;
2. Be completed for the correct cost-reporting period (Note that the accountability reporting period has been prepopulated. See **Step 4**. If provider believes that the dates are incorrect, contact HHSC Provider Finance at costinformationpfd@hhs.texas.gov for assistance);
3. Be completed using an accrual method of accounting (except for governmental entities required to operate on a cash basis);
4. Be submitted online as a 2022 Accountability report for the correct program through STAIRS;
5. Include any necessary supporting documentation, as required, uploaded into STAIRS;
6. Include signed, notarized, original certification pages (Accountability report Certification and Methodology Certification) scanned and uploaded into STAIRS
7. Calculate all allocation percentages to at least two decimal places (i.e., 25.75%);
8. Have uploaded into STAIRS a property valuation statement(s) from the local taxing authority or an independent appraisal approval letter from HHSC Provider Finance if required by 1 TAC §355.306(g)(2)(B);
9. Have uploaded into STAIRS a management contract and/or lease agreement, if applicable;
10. 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. A 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 report 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 accountability reporting period and paid within 180 days of the end of the accountability 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 particular business component.

Certain costs are required to be direct-costed including: medical/health/dental insurance premiums, life insurance premiums, other employee benefits (such as employer-paid disability premiums, employer-paid retirement/pension plan contributions, employer-paid deferred compensation contributions, employer-paid child day care, and accrued leave), attendant care staff salaries and wages and attendant contract labor compensation (see ***Definitions,*** *Attendant Care for Community* for detailed instructions on the reporting of attendant care staff time, salaries and wages) and, for Nursing Facilities only, direct care staff (e.g. RNs, LVNs, medication aides and certified nurse aides) salaries and contract labor compensation (see ***Definitions,*** *Direct Care for Nursing Facilities* for detailed instructions on the reporting of direct care staff time, salaries and wages).

For all attendant care and, for nursing facilities, direct care costs, the provider must have documentation that demonstrates the reported costs directly benefited only the program and contracts for which the accountability report is being completed. Daily timesheets documenting time are required for all attendant salaries directly charged to the accountability report. If the employee only works for the provider in one program and one position type, the daily timesheet must document the start time, the end time and the total time worked. If the attendant works in different programs or in more than one position type (such as habilitation attendant and file clerk), there must be daily timesheets to document the actual time spent working for each provider, program or position type so that costs associated with that employee can be properly direct costed to the appropriate cost area.

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 another 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 accountability 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 accountability-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.

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)

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) staff to ensure the fiscal integrity of the program. Accountability report audits are performed in a manner consistent with generally accepted auditing standards (GAAS), which are included in Government Auditing Standards: Standards for Audit of Governmental Organizations, Programs, Activities, and Functions. These standards are approved by the American Institute of Certified Public Accountants and are issued by the Comptroller General of the United States.

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

1 TAC §355.105(f) and §355.106

For desk reviews and field audits where the relevant records are located outside the state of Texas, the provider's financial records must be made available to HHSC's reviewers 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.

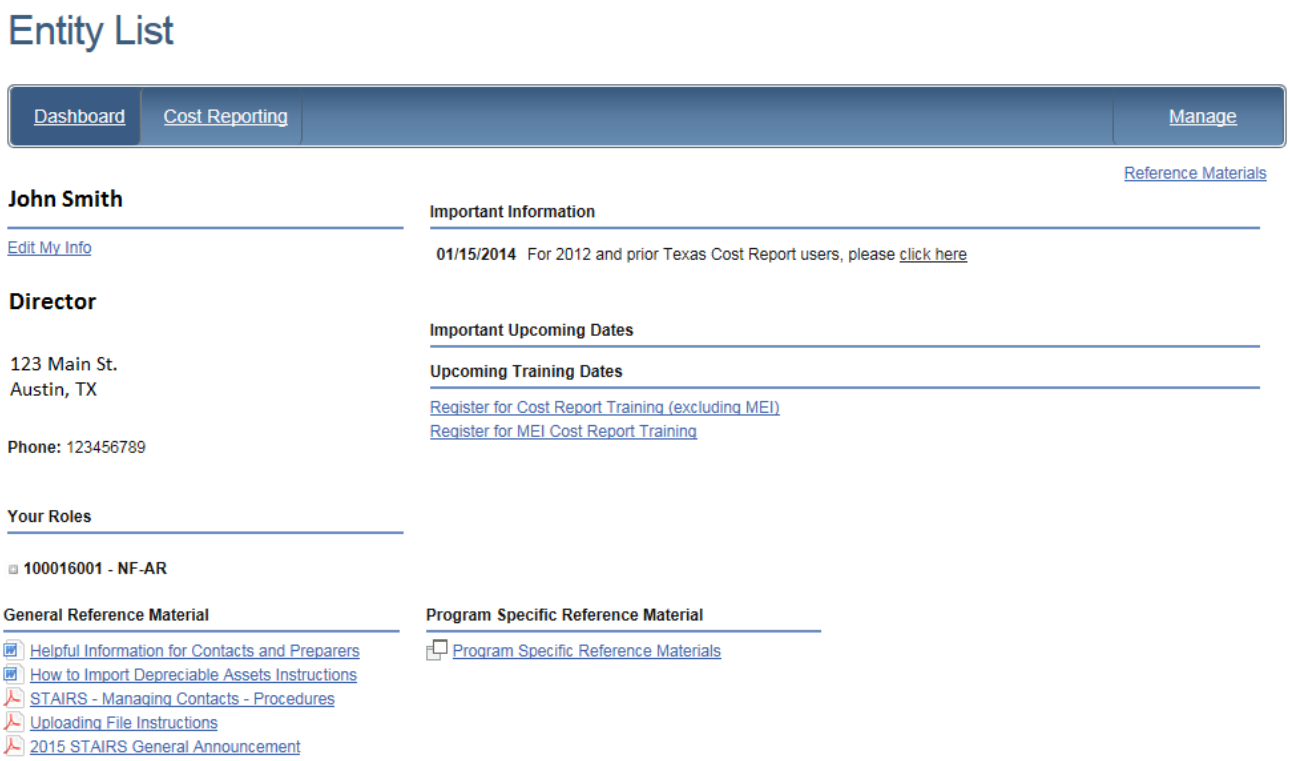
Save: Used to save the current data. This will save the information in the current location and allow additional Add, Edit or Delete actions.

Save and Return: This saves the current data and returns to the prior level web page.

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

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 web page, 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 web page.

User Interface and Dashboard



The initial web page 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 accountability report group, for example Accountability Report Group 001 for two PHC and Two PHC contracts, then there will only be one option to click on the initial Accountability Reporting page. If the user has access permission for more than one accountability report group, for example Accountability Report Group 002 for one CLASS CMA contract and two CLASS DSA contracts, and Component Code 8zz for HCS/TxHmL, then the user will need to choose the component code and report in which the user wishes to work.

Combined Entity Data

Step 1. Combined Entity Identification

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 on the Entity Contact Certification. The contact person should be able to answer questions about the contents of the provider's accountability 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 Methodology Certification completes the required HHSC-sponsored cost report training. The STAIRS cost/accountability reporting application will identify whether the person designated as a preparer has completed the required training. Only a preparer who has received credit for one of the cost report trainings (detailed in the next paragraph) from HHSC for both the General and the Program Specific training will be able to complete a accountability report in STAIRS. A list of preparers who have completed the training may be accessed through the Provider Finance website (see the Website section of the Instructions) by scrolling down to the "Training Information" heading and clicking on "View Cost Report Training Information", then "Preparer List."

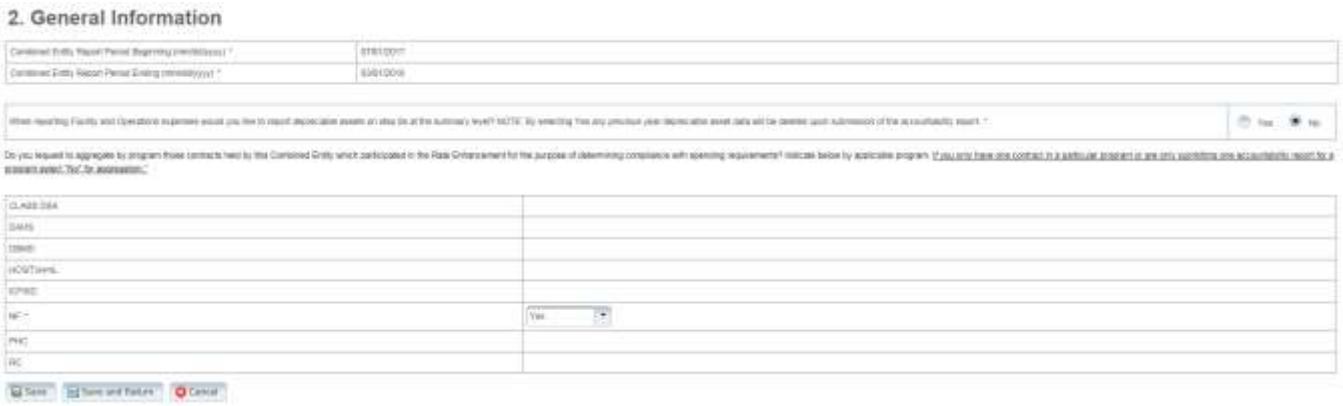
Preparers must complete cost report training for every program for which a cost and/or an accountability report is submitted. Such training is required every other year for the odd-year cost and/or accountability report in order for the preparer to be qualified to complete both that odd-year cost report and the following even-year cost and or accountability report. To sign as preparer of a 2021 or 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 accountability report preparer. All working papers used in the preparation of the accountability 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



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 accountability report in a prior year, these dates will be based on the dates from the prior accountability 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 contracts 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 contracts that participate in the Direct Care Staff 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. If there is only one contract or it is a single report then Not Applicable should be selected.

Step 3. Contract Management

Step 3.a. Verify Contracts for Requested Reports

This is a list of NF contracts operated by the provider's combined entity grouped by Cost/Accountability Report Group Codes. For each accountability/cost report group, the preparer must indicate in the left-most column whether the component code or all contracts in the Accountability Report Group were active during the entire accountability report 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 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 accountability reports for the combined entity being returned as unacceptable.

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 web page 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.

Note: Do not add contracts in **Step 3.b.** that are already listed in **Step 3.a.**

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 durable medical equipment 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 durable medical equipment 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.

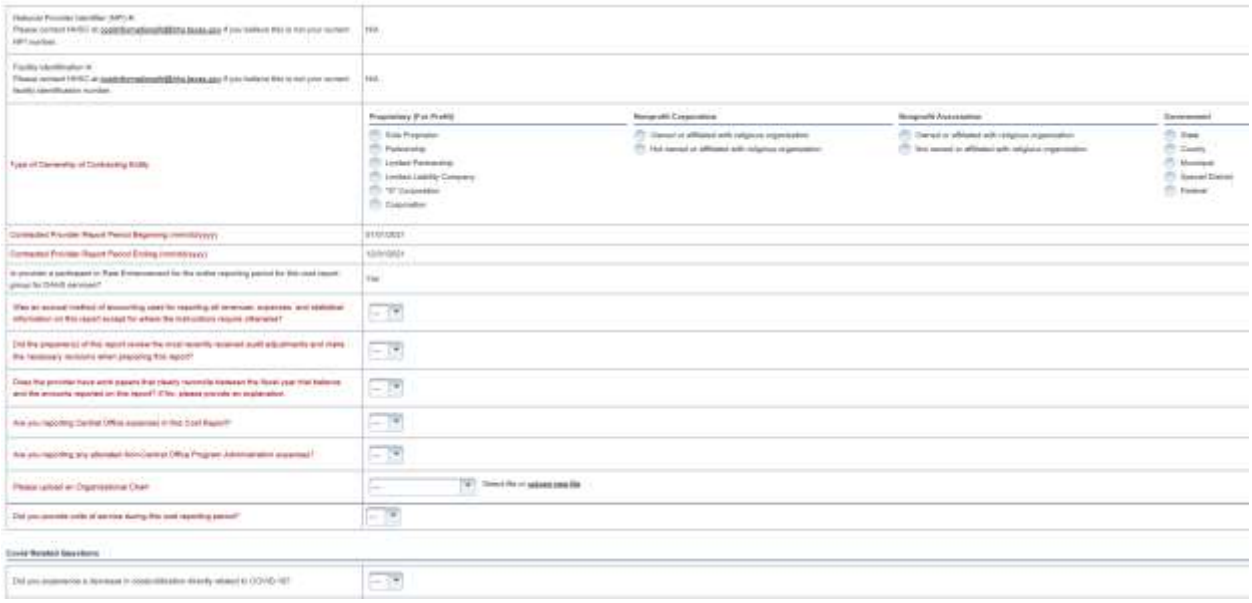
Step 3.c. Verify Business Component Summary

This web page lists all accountability report groups, 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.

Note: Step 3.a. is pre-populated with the Medicaid contract numbers, so you do not need to enter them anywhere else in the report. **Step 3.b.** is only for Non-Medicaid contracts, and then **Step 3.c.** is the summary of all. So, if Medicaid contracts are entered in **Step 3.b.**, they will show up twice in **Step 3.c.**

Step 4. General Information

From this point forward in the instructions, all requested information must be reported based only on the accountability report group and appropriate reporting period 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.

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:

The reporting period is any period of time between February 1, 2021 and December 31, 2022, during which the provider was a participant in rate enhancement. The reporting period is specified in the HHSC Provider Finance letter requesting the Accountability Report and does not exceed 12 months. Refer to the instructions for items 6 and 7 below for further direction on determining your reporting period.

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.

If the provider's reporting period is less than twelve months, the preparer must properly report only those statistics, revenues and expenses associated with the reporting period.

For example, if the provider's reporting period was 2/1/2019 through 12/31/2019, it is unacceptable for the report preparer to report 11/12 of the provider's annual days of service, annual revenues, and annual expenses. Instead, the preparer should only report information related to the reporting period, meaning that units of service, revenues, and costs related to the month of January 2019 are not to be included anywhere on the accountability report.

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., units of service), revenues, and costs associated with the actual accountability -reporting period. If, for example, the provider's cost-reporting period was 8/15/2019 through 12/31/2019, 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 8/15/2019 through 12/31/2019. 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 Direct Care Staff Compensation Rate Enhancement for Nursing Facility 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 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 accountability 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.

Does the provider have work papers that clearly reconcile between the fiscal year trial balance and the amounts reported on this report? If No, please provide an explanation.

Click either "Yes" or "No". When a provider clicks "Yes", then the workpapers must be uploaded to the report. There should not be situations where a provider responds to this question with "No." Each provider must maintain reconciliation work papers and any additional supporting work papers (such as invoices, canceled checks, tax reporting forms, allocation spreadsheets, financial statements, bank statements, and any other documentation to support the existence, nature, and allowability of reported information) detailing allocation of costs to all contracts/grants/programs/business entities. In order to facilitate the audit process, it is thus required that the accountability report 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).

If the response to the question above was "Yes", then Steps 6.d. and 8 will be grey and the preparer will not be able to make entries in those Steps.

Recoupment of funds from facilities whose Medicaid direct care staff spending is less than their spending floor may be mitigated (i.e., reduced) if the facility has high dietary and/or fixed capital costs. This mitigation is limited to recoupment amounts based upon failure to meet direct care staff spending requirements. There is no mitigation of recoupment for failure to meet staffing requirements. Facilities claiming mitigation must complete **Steps 6.d. and 8** of this report. Facilities waiving their right to mitigation do not have to complete **Steps 6.d. and 8**. Indicate "Yes" if you **are** waiving your right to mitigation and leave **Steps 6.d. and 8** blank. Indicate "No" if you **are not** waiving your right to mitigation and complete **Step 6.d. and 8**.

Did you provide Direct Care Units 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

Step 5.a. Statistical Data

Step 5.b. Bed Days

In this web page the preparer will enter the Medicaid days of service and Resource Utilization Group (RUG) and the Non-Medicaid units of service in Medicaid contracted beds. The provider must breakdown the Medicaid units into multiple rate periods based on when the Medicaid payment rates changed during the provider's accountability report 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.

Report "pending" residents in the category believed they are most likely to be classified by HHSC until they have been certified and qualified. Days for which residents were charged for "room hold" or "bed hold" are not considered as days of service and are not to be counted as resident days see **Step 5.d.**.

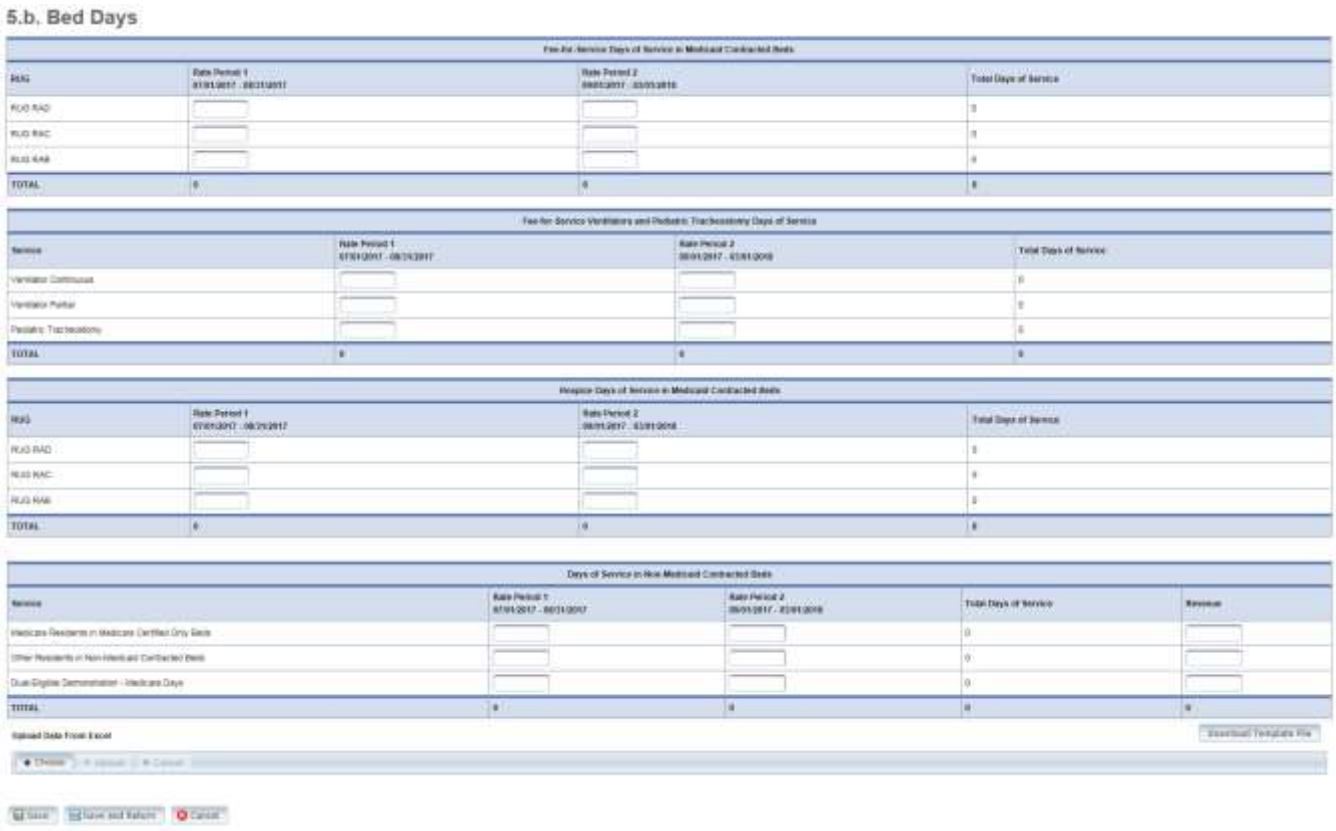
Days of service for HHSC residents under the Respite program should be reported in **Step 5.b.** Private Residents in Medicaid-Contracted beds or **Step 5.c.** Other Residents in Non-Medicaid Contracted Beds, depending upon whether the bed is contracted for Medicaid or not contracted for Medicaid.

If the facility does not accept private insurance payments but a resident's family accesses private insurance for funds to pay the facility for the resident's care, the resident is considered a private resident and this resident's days of service should be reported in Step 5b Private Insurance Residents in Medicaid Contracted beds or **Step 5.c.** Other Residents in Non-Medicaid Contracted Beds, depending upon whether the bed is contracted for Medicaid or not contracted for Medicaid.

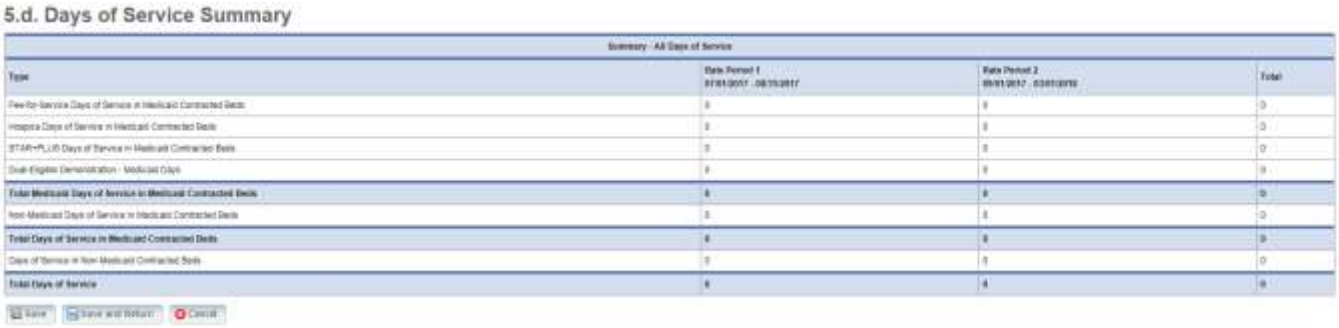
Non-Medicaid revenues include revenues received for Private residents in Medicaid-Contracted beds and revenues received for residents in Non-Medicaid-Contracted beds.

Enter the Days of Service in Non-Medicaid Contracted Beds for Medicare Residents in Medicare Certified Only Beds, Other Residents in Non-Medicaid Contracted Beds, and Dual-Eligible Demonstration - Medicare Days. These units must be broken out for each date range that falls in the reporting period

The following web pageshot shows a portion of the entry web page for the units of service by RUG code; the actual step includes more RUG codes and tables for Hospice, Star+Plus, and Dual-Eligible. Following that are the web pageshots for the other tables included in Step 5b.



Step 5.d. Days of Service Summary



Step 6. Wages and Compensation

Step 6.a. General Information

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. Please note, this report is for Attendant compensation only, if the related party does not perform attendant services the expenses are not to be included on this report and answer should be "No". If the related party performs multiple functions, then an allocation summary must be submitted that indicates the breakdown of Attendant / non-Attendant wages. If the preparer clicks "Yes" then the Step on the main Wages and Compensation page called **Step 6.b.** will be activated for entry.

Step 6.b. Related-Party

This Step will be disabled 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.

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 through 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.** If a business component that should receive a portion of the allocated cost of the item(s) is not in the drop-down menu, then the preparer should return to **Step 3.b.** and enter the missing business component data. 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.

C. Hours – On the grey bar, enter hours allocated or direct costed to each business component. Compensation amount will be automatically calculated.

D. Line Item – The drop-down menu includes all staff types reportable in this 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.

E. Job Title – Related Party's title within the specific business component

F. 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.

G. 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 accountability report, and reference that upload in this item.

H. 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.

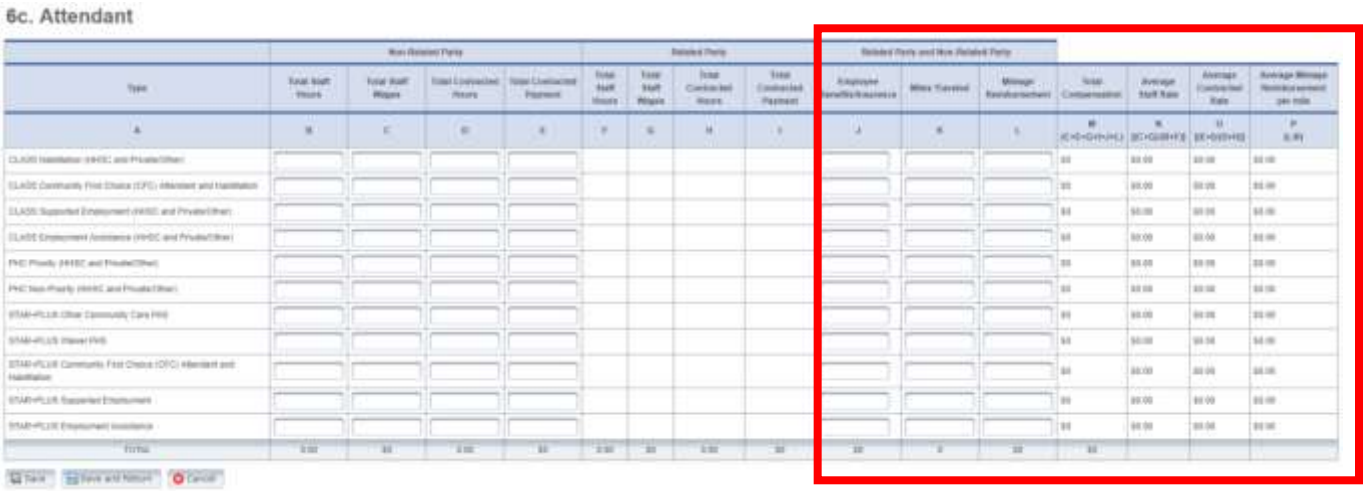
I. Total Hours Worked – Enter hours allocated or direct costed to each area. Allocate or direct cost all hours reported for the individual for the business component to an area before proceeding. Compensation will automatically be calculated.

J. 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.

K. 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.

L. 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**. All related-party attendants must be entered through **Step 6.b.** above. For each attendant staff service type (CLASS Hab, CLASS Community First Choice, CLASS Supported Employment, CLASS Employment Assistance, PHC Priority, PHC Non-Priority, STAR+PLUS SPW and STAR+PLUS Non-SPW) 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.).

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.

Employee Benefits/Insurance: This column is for BOTH related and non-related party employee attendant staff. For all attendants, by service 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. See 1 TAC §355.103(b)(1)(A)(iii)(III)(-c-).

Note: Costs that are not employee benefits Per 1 TAC §355.103(b)(1)(A)(iii)(II), the contracted provider's unrecovered cost of uniforms, staff personal vehicle mileage reimbursement, job-related training reimbursements and job certification renewal fees are not to be reported as benefits but are to be reported as costs applicable to specific accountability report line items in **Step 8.f.**, unless they are subject to payroll taxes, in which case they are to be reported as salaries and wages. See 1 TAC §355.103(b)(1)(A)(iii)(III)(-e-) and instructions on meals for staff, supplies for staff meal preparation, staff personal vehicle mileage reimbursement and housing costs for live-in staff for further direction on the correct reporting of these costs.

Miles Traveled and Mileage Reimbursement: These columns are for BOTH related and non-related party employee attendant staff. For all attendants, by service type, include the personal vehicle miles traveled and the mileage reimbursement paid for allowable travel and transportation in the staff person’s personal vehicle. Allowable travel and transportation includes mileage and reimbursements of attendant staff who transport individuals to/from NF and Community Care program services and activities in their personal vehicle, unless payroll taxes are withheld on the reimbursements, in which case should be included as salaries and wages of the appropriate staff. Allowable travel and transportation also includes mileage and reimbursements of attendant staff for allowable training to which they traveled in their personal vehicle.

The maximum allowable mileage reimbursement is as follows:

- 1/1/20 – 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 service type.

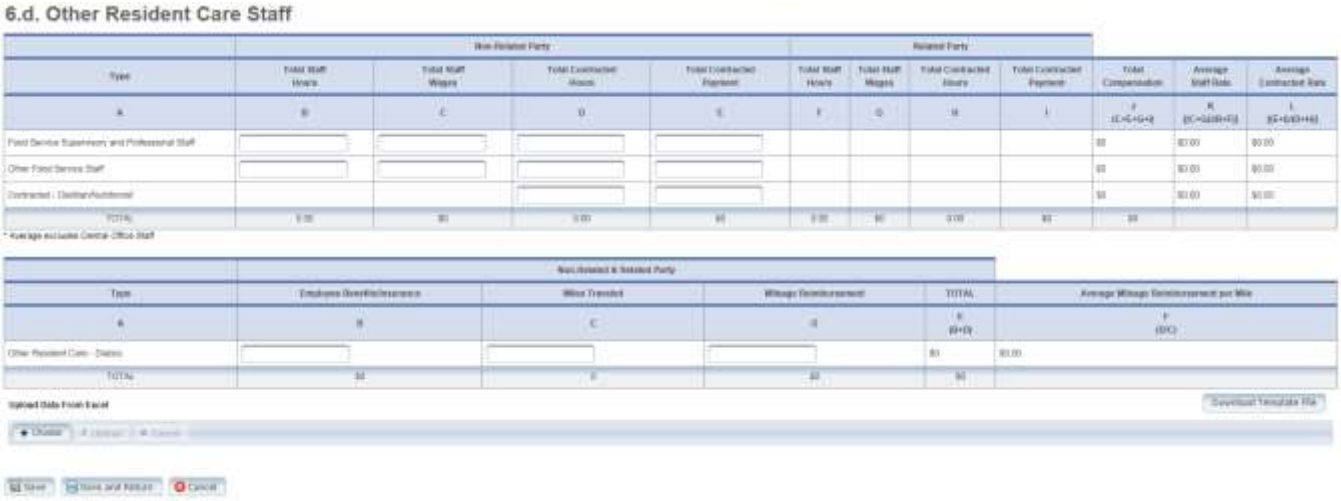
Column N: Average Staff Rate: This column is the result of Columns C + G divided by Columns B + F and represents the average hourly wage rate of all employee staff, both related party and non-related party.

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 6.d. Other Resident Care Staff

If the response to the question "Do you choose to waive your right to mitigation of any recoupment amounts related to failure to meet spending requirements for the reporting period" in **Step 4** was "Yes", then **Step 6.d.** will be grey, and the preparer will not be able to make entries.



For the upper sections (by facility type – only facility types contracted by the provider will be visible):

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 staff of the listed staff types only. Compensation for administrative staff types will be collected in a separate Step of the accountability report. All related-party staff must be entered through Step 6.b. above. For each facility and for each staff type enter hours, wages and contract compensation for non-related party employees and contract staff. See staff type descriptions below. All staff reported here perform either non-direct care or indirect care functions.

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

Pay for being "on-call" is reported as salaries by staff type but only on-call hours actually worked performing a specific function can be reported as time. For example, if a RN was on call for an entire weekend and received $200 as on-call compensation, the total $200 would be reported as wages or compensation. If the RN was required for three hours to provide assistance to staff while on-call during the weekend, only three hours would be reported as paid hours and not the full 48 hours of the weekend.

Allocation of Shared Dietary/Central Kitchen Expenses

A central kitchen is defined as a kitchen that provides meals and/or snacks to more than one contract, component code program, or business entity. If the provider had a central kitchen that prepared meals for more than one business entity or NF contract, the accountability report preparer CANNOT report the expense of the meals provided for this NF contract as a single line item entry on the accountability report. Shared dietary/central kitchen expenses must be reported on the accountability report in the various line items that reflect the types of expense (i.e. Dietary Staff wages and compensation in this cost item and facility, equipment, food and dietary supplies expenses in *Step 8**.***

If dietary care services are shared by more than one business component (e.g., with an adult day care, residential care, independent living and/or child day care) or multiple NFs, the shared dietary costs must be properly allocated. If the services are provided by a central kitchen, see **Appendix C** for details as to proper allocation of these expenses.

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 staff as described above reported in *Step 6b*, these columns are automatically populated after all nonrelated-party costs in Columns B-E have been entered.

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

Column K: 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 L: 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.

Other Resident Care - Dietary:

Column A: Employee Benefits/Insurance: This column is for BOTH related and non-related party employee direct care staff. For all direct care staff, 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-).

Note: Costs that are not employee benefits Per 1 TAC §355.103(b)(1)(A)(iii)(II), the contracted provider's unrecovered cost of meals and room-and-board furnished to direct care staff, uniforms, staff personal vehicle mileage reimbursement, job-related training reimbursements and job certification renewal fees are not to be reported as benefits but are to be reported as costs applicable to specific accountability report line items in **Step 8.f.**, unless they are subject to payroll taxes, in which case they are to be reported as salaries and wages. See 1 TAC §355.103(b)(1)(A)(iii)(III)(-e-) and instructions on meals for staff, supplies for staff meal preparation, staff personal vehicle mileage reimbursement and housing costs for live-in staff for further direction on the correct reporting of these costs.

Columns B and C: Miles Traveled and Mileage Reimbursement: These columns are for BOTH related and non-related party employee direct care staff. For all direct care staff, by facility size and staff type, include the personal vehicle miles traveled and the mileage reimbursement paid for allowable travel and transportation in the staff person's personal vehicle. Allowable travel and transportation includes mileage and reimbursements of direct care staff who transport individuals to/from services and activities of the NF in their personal vehicle, unless payroll taxes are withheld on the reimbursements, in which case they should be included as salaries and wages of the appropriate staff. Allowable travel and transportation also includes mileage and reimbursements of direct care 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 F: Average Mileage Reimbursement per Mile: This column is the result of Column D divided by Column C. This amount should never be greater than the highest allowable mileage rate for the provider's fiscal year.

Step 7. Payroll Taxes and Workers' Compensation

Report costs for all staff in this Step.

Report costs for direct care staff, non-direct care staff/ 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 Direct Care and Dietary Care.

FICA & Medicare Payroll Taxes

Report the cost of the employer's portion of these taxes. Do not include the employee's share of the taxes. Unless the provider has indicated that they participate in a Section 125 or Cafeteria Plan that covers the employees for insurance premiums, unreimbursed medical expenses and/or dependent care costs or the provider has reported staff who are paid in excess of the FICA Wage Limit ($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 accountability 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) and ***Appendix E.***

Step 8. Facility and Operations Costs

If the response to the question "Do you choose to waive your right to mitigation of any recoupment amounts related to failure to meet spending requirements for the reporting period" in **Step 4** was "Yes", then **Step 8** will be grey and the preparer will not be able to make entries.

Step 8.a. General Information

Were there any related-party loans?

Click either "Yes" or "No". If "Yes", ***Step 8c (Related-Party Loans)*** will become available for entry of related-party loan transactions. Refer to **Definitions**, *Related Party* and *Related-Party Transactions.*

Was the nursing facility building leased during the cost-reporting period?

Indicate whether or not the nursing facility building was leased during all or part of the accountability report period, and if so, indicate whether it was leased from a Non-Related Party or a Related Party. If the facility was leased during any part of the accountability report period, you will need to upload a Copy of the Lease Agreement, and HHSC Schedule D1 or other similar documentation. Submission of the lease agreement with a prior year's accountability report does not exempt a facility from the requirement to submit another copy with the current Schedules and attachments to the accountability report.

Steps 8.b.- 8.d. Related-Party Transactions

Note: Steps 8b and 8d are not required data for the Accountability Report.

See 1 TAC §355.102(i) for specific details and requirements on related-party transactions. If the response to the question "Were there any related-party loans" **Step 8.a.** above was "No", then **Steps 8.c.** will be grey, and the preparer will not be able to make entries. 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 these three Steps.

The lease or purchase of services (including lending/loan services), facilities, equipment and supplies from related organizations or related individuals by the provider or the provider's central office must be reported as a related-party transaction. Note that for depreciation expenses, related-party status is disclosed separately for each depreciable item when depreciation, amortization and other expenses for related-party and non-related-party assets are entered. In addition, purchases made from a related party by the central office for services, facilities, and supplies must also be reported as related party transactions. An exception is central office costs allocated to the provider that contain no markup (i.e., the cost allocated to the provider is the cost incurred by the central office); these do not have to be reported as related party transactions. This exception does not apply to related-party management costs; these costs must always be reported as central office costs.

Expenses in related-party transactions are allowable at the cost to the related organization; however, the cost must not exceed the price of comparable services, equipment, facilities, or supplies that could be purchased or leased elsewhere in an arm's-length transaction. The related organization's costs include all reasonable costs, direct and indirect, incurred in the furnishing of services, equipment, facilities, leases, and supplies to the provider. The intent is to treat the costs incurred by the supplier as if the contracted provider itself incurred them. Therefore, if a cost would be unallowable if incurred by the contracted provider, it would be similarly unallowable to the related organization.

See **Definitions**, Related Party and Related-Party Transactions.

EXCEPTIONS TO THE RELATED-PARTY RULE

An exception (1 TAC §355.102(i)(5)) is provided to the general rule applicable to related organizations if the contracted provider demonstrates for each accountability report that certain criteria have been met. If all of the conditions of this exception are met, the charges by the related-party supplier to the contracted provider for services, equipment, facilities, leases, or supplies are allowable costs and do not have to be reported as related-party transactions. Written requests for an exception to the general rule applicable to related organizations must be submitted for approval to HHSC's Provider Finance Department no later than 45 days prior to the due date of the accountability report in order to be considered for that year's accountability report. The provider's request for an exception must demonstrate that all of the following criteria have been met:

The supplying organization is a bona fide separate organization. See 1 TAC §355.102(i)(5)(A).

1. A majority of the supplying organization's business activity of the type carried on with the contracted provider is transacted with other organizations not related to the contracted provider and the supplier by common ownership or control. See 1 TAC §355.102(i)(5)(B).
2. There is an open, competitive market for the type of services, equipment, facilities, leases, or supplies furnished by the related organization. See 1 TAC §355.102(i)(5)(B).
3. The services, equipment, facilities, or supplies are those which commonly are obtained by entities such as the contracted provider from other organizations and are not a basic element of contracted care ordinarily furnished directly to individuals by such entities. See 1 TAC §355.102(i)(5)(C).
4. The charge to the contracted provider is comparable to open market prices and does not exceed the charge made to others by the organization for such services, equipment, facilities, leases or supplies. See 1 TAC §355.102(i)(5)(D).

If Medicare has made a determination that a related-party situation does not exist or has granted an exception to the related-party definition, and the provider desires that HHSC accept that determination, the accountability report preparer must submit a copy of the applicable Medicare determination, along with evidence supporting the Medicare determination for the current cost-reporting period with each affected accountability report. If the exception granted by Medicare is no longer applicable due to changes in circumstances of the contracted provider or because the circumstances do not apply to the contracted provider, HHSC can choose not to accept the Medicare determination. *See 1 TAC §355.102(i)(5).* If the request for a related-party exception is not received at least 45 days prior to the due date of the accountability report, HHSC Provider Finance is not required to process the request for that cost-reporting year.

Step 8.c. Related-Party Loans

Report in this Step any related-party loans from individuals or organizations. Actual interest properly accrued and paid on related-party loans is an allowable cost, but is

limited to the interest that would have been charged during the reporting period had the interest rate on the loan been set at the prevailing national average prime interest rate in effect at the time at which the loan contract was finalized, as reported by the United States Department of Commerce, Bureau of Economic Analysis, in the Survey of Current Business. The best and quickest source of prime interest rate information is the Federal Reserve Bank of St. Louis Web Site (http://www.stlouisfed.org/) under Research and Data, FRED® (Federal Reserve Economic Data) Economic Data, Categories, Interest Rates, and Prime Bank Loan Rate. This data series extends back to 1949 and is updated monthly.

All columns must be completed for each related individual or organization.

A. Name of Related Party/Organization – Enter the name of the related party or organization from whom the contracted NF purchased or leased equipment and/or supplies. If the contracted provider is a proprietorship, the related organization could be the individual owner rather than a separate corporation. If the contracted provider is a partnership, the related organization could be one of the partners.

B. Description – Must be chosen from the drop-down menu – either Mortgage Interest or Other. This is the line item on which the allowable cost will appear in the accountability report.

C. Please describe – If Other was chosen for B above, describe the type of loan.

D. Inception Date – Month and year the loan was effective.

E. Loan Amount – This should be the total amount of the loan.

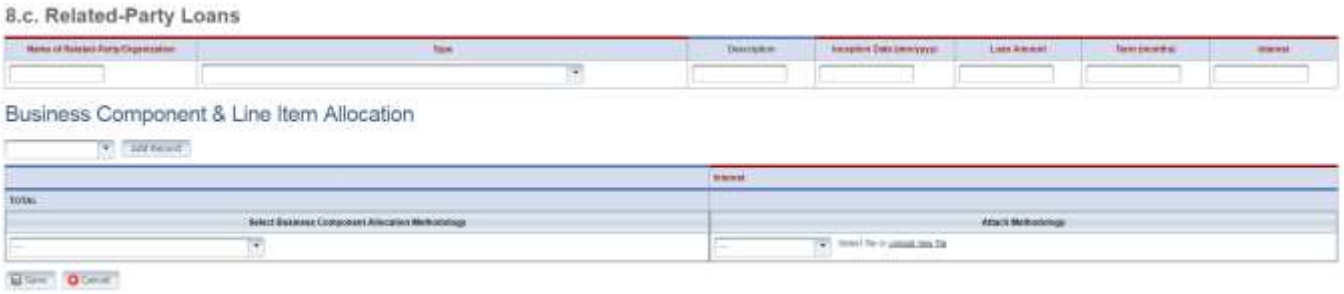
F. Term – Duration of the loan in months.

G. Interest – Allowable interest paid during the reporting period.

1. Click "Save" to enter Contract Number and Cost Area Allocation(s)

   The available business components are limited to the businesses and contracts entered in the **Step 3**. If a business component that should receive a portion of the allocated cost of the item(s) is not in the drop-down menu, then the preparer should return to **Step 3.b.** and enter the missing business component data. Allocate or direct cost all interest reported for the Related Party/Organization to a business component before proceeding. If allocated, an allocation method must be chosen, and an allocation summary uploaded.

   •



   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 Cost Area information for each business component. Choose and Click "Add Record" until all business components to which this interest expense will be allocated have been added.

2. Enter all Cost Area Information

   A. Interest – On the grey bar, enter the allowable interest expense allocated or direct costed to each business component.

   B. Area – The dropdown menu for "Area" includes all cost areas reportable in this accountability report. See **Step 8.f.** for a detailed discussion of Cost Areas. Central Office may only be used for expenses of a central office that are allocated between multiple business components. Costs of a central office which can be directly charged to the contracted provider should be reported as Program Administration. See **Definitions**, *Central Office*.

   C. Interest – Enter the allowable interest expense direct costed or allocated to this cost area within the business component.

   D. Cost Area Allocation Methodology – If allocated to multiple cost areas, an allocation method must be chosen, and an allocation summary uploaded. This will be required only if there were multiple cost areas selected.

   E. Business Component Allocation Methodology – After all business component cost area allocations have been completed, an expense that is allocated to multiple business components will also require that a business component allocation method be chosen, and an allocation summary uploaded.

Step 8.e. Depreciation Expense and Related-Party Lease/Purchase of Depreciable Assets

Providers have an option of reporting each single capital asset in Step 8e and allowing the system to depreciation expense per category at the summary level in Step 8e.

Depreciable asset information automatically populates from year to year after the initial entry. After the first year, providers will only need to adjust allocations of shared assets to correctly report current year allocation percentages and add new assets. A provider with numerous assets may want to import their basic asset information. This information may be imported into STAIRS. See **Appendix F.**

Note: If a provider, in a subsequent year's accountability report, chooses to enter their depreciation at the summary level any previously entered depreciable asset data will be deleted upon submission of the accountability report.

For cost-reporting purposes, property and assets owned by the contracted provider and improvements to the provider's owned, leased, or rented property that are valued at $5,000 or more with an estimated useful life of more than one year at the time of purchase must be depreciated. Any single item costing less than $5,000 should be expensed and reported as supplies in the applicable cost area. For example, a non-depreciable mixer/blender would be reported as Food and Dietary Supplies; a non-depreciable calculator and a non-depreciable resident nightstand would be reported as Resident Care and Operations Supplies.

Depreciation for depreciable items must be calculated using the appropriate Steps of the accountability report.

For depreciable assets leased from a related party, all costs to be entered are the cost to the related party, not payments by the contracted provider to the related party. For depreciable assets purchased from a related party, the cost entered must be the cost to the related party and not the amount actually paid by the contracted provider for the asset purchased.

NOTES

Allowable depreciation expense includes only pure straight-line depreciation. No accelerated or additional first-year depreciation is allowable.

Include only assets of the contracted provider or its central office that are used directly or indirectly in the provision of resident care during the cost-reporting period. For shared central office depreciation, show the percentage allocated to the contracted provider for which the accountability report is being prepared and cross-reference to the applicable allocation summary. For shared facility-level depreciation (e.g., depreciation of assets whose usage is shared between the contracted provider and another entity), show the amount allocated to the contracted provider by cost area and cross-reference the applicable allocation summary.

Required detail must be provided for each depreciable asset and each depreciable asset will be assigned a correct estimated useful life as required by 1 TAC §355.103(b)(10)(A-C).

1. Click "Add Record"
   A. Is this a shared asset? – Click "Yes" or "No". If "Yes", the preparer will be asked to allocate the asset between business components and cost areas after saving. If "No", the system will automatically assign the asset to the current accountability report.
   B. Related-Party or Non-Related Party – Click "Related Party" if the asset was purchased or leased from a related party or "Non-Related Party" if the asset was purchased from a nonrelated party.

      NOTE - Only Related-Party leases are reported through the Depreciation web pages. Nonrelated-party leases are reported in **Step 8.f**.

      a) Asset – This is the line item on which the allowable cost will appear in the accountability report. If it is a related-party lease, then a drop-down menu with additional expense types will be available for entry of related-party cost. The various types of assets include:

         i. ***Depreciation: Buildings and Building Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, or Other Amortization***

         ii. ***Buildings and Building Improvements:*** Structures (and depreciable improvements to those structures) consisting of building shell or frame, building components, exterior walls, interior framing, walls, floors, and ceilings. The building cost can also include a proportionate share of architectural, consulting, and interest expense (incurred during the construction of the building, not mortgage interest) associated with a newly constructed or renovated building

(including major additions). Buildings do not include central air conditioning systems and trade fixtures, unless they were part of the building when purchased/renovated. Building improvements that are structural in nature (renovations) should be depreciated as if they were a building. Such improvements should be assigned a life of at least 30 years and a salvage value of at least 10%. When a portion of a building is renovated, and all parts of the renovation are placed in service at or about the same time, the renovation should be depreciated as a single depreciable asset over 30 years and not over the estimated life of each of its components. Building improvements that are not structural in nature and do not extend the depreciable life of the building, but whose estimated useful lives are longer than the remaining depreciable life of the building, must be depreciated over the normal useful life of the building improvements. Providers who rent or lease their building must report any building improvement depreciation as leasehold improvement depreciation.

iii. ***Building Fixed Equipment:*** Any equipment which is attached to the building and is intended to be permanent, such as central air conditioning systems and trade fixtures. Providers who rent or lease the facility must report any building fixed equipment depreciation as leasehold improvements depreciation.

iv. ***Leasehold Improvements:*** Improvements a lessee makes to a leased building. These improvements are attached to the building or land in a permanent way. They become the property of the lessor when the lease is terminated. Examples of leasehold improvements are permanent trade fixtures, additions, and betterments. All building equipment and land improvements purchased by a lessee, that are valued at $5,000 or more at the time of purchase with an estimated useful life of more than one year must be classified as a leasehold improvement and amortized. Leasehold improvements whose estimated lives are longer than the lease term must be amortized over the life of the leasehold improvement.

v. ***Land Improvements:*** Assets found on the land area contiguous to, and designed for serving, the contracted provider such as fences, sidewalks, driveways, parking lots, etc. The asset can include a proportionate share of the architectural, consulting, and interest expense associated with newly constructed or renovated buildings. Providers who rent or lease the facility must report land improvement depreciation as leasehold improvement depreciation.

vi. ***Research and Development (R&D), Organizational and Start-up:*** Must be amortized over a period of at least sixty months. R&D costs include those costs related to determining the business feasibility of obtaining a contract and can include costs such as demographic research and consulting fees. Organizational costs may include costs such as legal fees, state incorporation fees, stock certificate costs, underwriting costs, and office expenses incident to organizing the company. Start-up costs include those costs related to employee training, licensing, utilities, facility cleaning, and other preparations that are incurred before the first individual (whether

Medicaid or non-Medicaid) is admitted to the program. 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 capitalizable construction costs must be appropriately classified as such and excluded from startup costs. *Costs related to care for individuals that are incurred after the first individual is admitted, but before the provider is Medicaid-certified, are unallowable costs.*

b) Depreciation: Departmental Equipment: Any equipment capable of being moved from one site to another, such as all types of furniture, appliances, office machines, and any other items of equipment which are necessary operating assets.

c) Depreciation: Transportation Equipment: Equipment used for the transport of individuals in care, staff or materials and supplies utilized by the provider in the provision of contracted care. Depreciation expenses for transportation equipment not generally suited or not commonly used to transport individuals in care, staff, or provider supplies are unallowable costs. This includes motor homes and recreational vehicles, sports automobiles, motorcycles, heavy trucks, tractors and equipment used in farming, ranching and construction. Lawn tractors are to be reported as departmental equipment.

d) (For related party only) Rent/Lease - Building and Building Equipment: Includes the assets in a) i. through iv. above that are rented or leased from a related party. Additional expense types for possible building-related costs to the related-party are optional entries.

i. Mortgage Interest – Mortgage interest for the property leased to the contracted provider that was properly accrued and paid by the related party.

ii. Interest-Other – Other interest expenses directly related to the property leased to the contracted provider that were properly accrued and paid by the related party.

iii. Property Tax – Property tax payments for the property leased to the contracted provider that were properly accrued and paid by the related party.

iv. Insurance Expense – Insurance expenses for the property leased to the contracted provider that were properly accrued and paid by the related party.

v. Other Expense – Other expenses directly related to the property leased to the contracted provider that were properly accrued and paid by the related party.

e) (For related party only) Rent/Lease – Departmental Equipment: includes the assets in b) above. Additional expense types for possible departmental equipment-related costs to the related-party are optional entries.

i. Interest-Other – Other interest expenses directly related to the property leased to the contracted provider that were properly accrued and paid by the related party.

ii. Other Expense – Other expenses directly related to the property leased to the contracted provider that were properly accrued and paid by the related party.

f) (For related party only) Rent/Lease – Transportation Equipment:
Includes the assets in c) above. Additional expense types for possible departmental equipment-related costs to the related-party are optional entries.

i. Transportation-Maintenance, Repairs, Gas, Oil, Interest, Insurance, Taxes, Other – Enter here only the Interest, Insurance and/or Repair and Maintenance expenses directly related to the transportation equipment leased to the contracted provider that were properly accrued and paid by the related party.

ii. Other Expense – Other expenses directly related to the property leased to the contracted provider that were properly accrued and paid by the related party.

A. Code (optional) – For internal provider use.

B. Month/Year Placed in Service (mm/yyy) - Enter the month and year that the asset to be depreciated was placed in service.

C. Description of Asset – This will be chosen from a drop-down menu populated from the AHA Guide discussed in Years of Useful Life below. If the preparer does not find the type of asset and cannot determine a close match, contact the Rate Analyst to determine if a new asset type should be added.

NOTE: If Building is selected, a drop-down menu will request an address. If the building is being leased (related parties only), a lease agreement must be uploaded.

D. Asset in Service at end of Period? – Click "Yes" or "No" to note whether this item was in service at the end of the accountability reporting period. If "Yes", enter the Month / Year placed in service. If "No", enter the Month / Year placed in service and the Month / Year removed from service.

E. Years of Useful Life – The time period over which the asset must be depreciated. STAIRS populates this based on the Description entered in E. above for all assets except Used Vehicles. Also see **Appendix D**

Minimum useful lives must be consistent with "Estimated Useful Lives of Depreciable Hospital Assets", published by the American Hospital Association (AHA) (2008 Version Item Number - Item No. 061179 ISBN: 978-1-55648-358-5).

Copies of this publication may be obtained by contacting:

Mail: AHA Services, Inc.; P.O. Box 933283; Atlanta, GA 31193-3283
Toll Free: 800-242-2626 Fax: 866-516-5817
Website: WWW.AHA.ORG/EUL

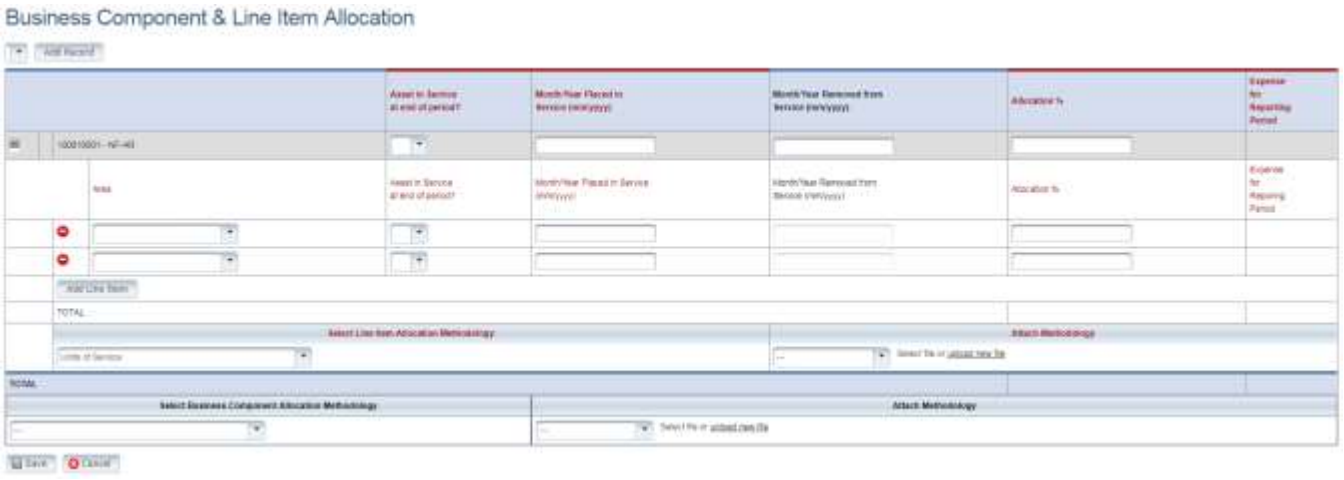
For Used Vehicles, determine the required useful life and enter that. Per 1 TAC 355.103(b)(10)(C)(ii), "The estimated life of a previously owned (used) vehicle is the longer of the number of years remaining in the vehicle's depreciable life or three years. For example, if a 2014 van were purchased in 2015, it would have four years remaining in its five-year depreciable life and that would become the depreciable life for the used vehicle. If a 2014 minivan were purchased in 2015, it would have two years remaining in its three-year depreciable life and the depreciable life for the used vehicle would then be three years."

F. Historical Cost – The cost of acquiring the asset and preparing it for use. Does not include goodwill or, for buildings, the cost of the land (land is not a depreciable item).

G. Salvage Value – This amount will be calculated automatically. Salvage value is the estimated residual value of the asset for scrap or salvage after its useful life has ended. All buildings must have a minimum salvage value of at least 10% of historical cost for Medicaid cost-reporting purposes. No other salvage values are required.
H. Depreciation Basis – Calculated figure equal to H minus I.
I. Prior Period Accumulated Depreciation – Calculated figure. Based on date placed in service and calculation of depreciation on the Depreciation Basis from that date to the beginning date of the accountability reporting period.
J. Depreciation for Reporting Period – Calculated figure. Based on the date placed in service, the beginning date of the accountability reporting period, any date entered as Month/Year removed from service) and the remaining useful life.
K. Total Expense for Reporting Period – Calculated figure. For Related-party leases, this will include costs from C. ***d) – f)*** above, as well as the depreciation on the asset.

2. Click "Save" to enter Business Component and Cost Area Allocation(s)

Business Component – The available business components are limited to the businesses and contracts entered in **Step 3**. If a business component that should receive a percentage of the asset or related-party leased items is not on the list, then the preparer should return to **Step 3.b.** and enter the missing business component data. Allocate or direct cost 100% of the asset costs a business component before proceeding. If allocated, an allocation method must be chosen and an allocation summary uploaded.



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 Cost Area information for each business component. Choose and Click "Add Record" until all business components to which this expense will be allocated have been added.

C. Information in the Business Component Grey Bar –

a) Asset in Service at End of Period? – The response for the business component will default to "Yes" if the Asset information above states that the asset itself was in service at the end of the period. This entry field allows for the possibility that the asset is taken out of service for a single business component, but not for all. The allocation of an asset may also change throughout a year. This question allows for flexibility in how asset allocation may change throughout a year.

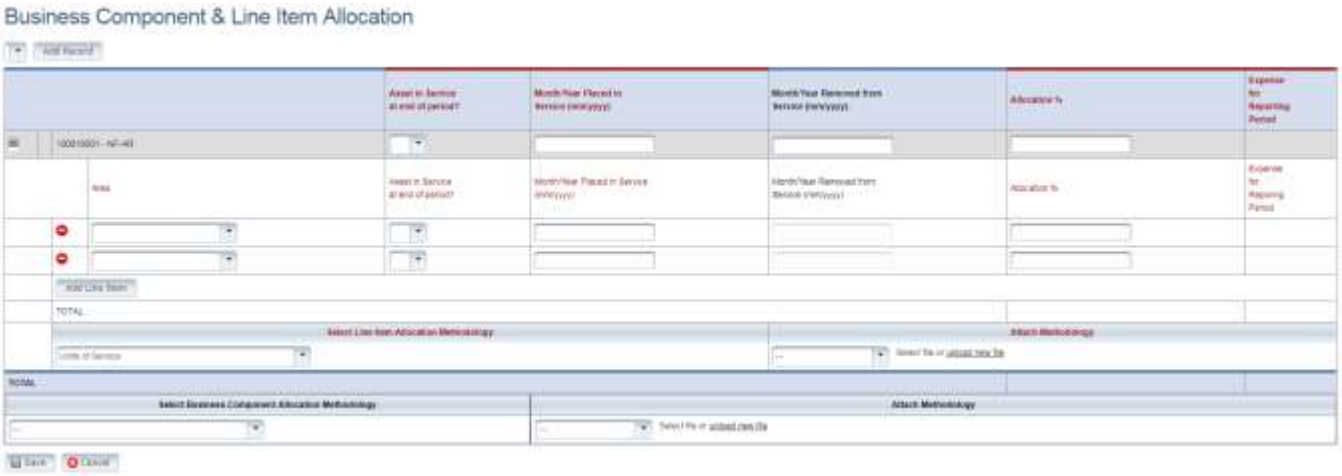
b) Month/Year Placed in Service (mm/yyyy) – Enter the month and year the asset was initially placed in service for depreciation purposes for this specific business component.

c) Month/Year Removed from Service (mm/yyyy) – If the asset was removed from service for this business component during the current year, then enter the month and year that the asset was removed from service.

d) Allocation % – The percentage of the costs to be allocated to this specific business component.

e) Expense for Reporting Period – Calculated figure based on the percentage(s) entered.

3. Enter all Cost Area Information



A. Area – The dropdown menu for "Area" includes all cost areas reportable in this accountability report. See **Step 8.f.** for a detailed discussion of Cost Areas. Central Office may only be used for expenses of a central office that are allocated between multiple business components. Costs of a central office which can be directly charged to the contracted provider should be reported as Program Administration. See **Definitions**, *Central Office*.

B. Asset in Service at End of Period? – The response for the cost area will default to "Yes" if the business component information above states that the asset itself was in service at the end of the period. This entry field allows for the possibility that the asset is taken out of service for a single cost area, but not for all. The allocation of an asset may also change throughout a year. This question allows for flexibility in how asset allocation may change throughout a year.

C. Month/Year Placed in Service – Enter the month and year the asset was initially placed in service for depreciation purposes for this specific cost area.

D. Month/Year Removed from Service – If the asset was removed from service for this cost area during the current year, then enter the month and year that the asset was removed from service.

   - The two lines above (c and D) also allow for changes in allocation percentages throughout the year. By entering an end date at the point where the allocation changes and adding an additional record with a new 'placed in service date' for the new allocation period, the usage changes will be taken into account in the calculation of the depreciation below.

E. Allocation% –The percentage of the costs to be allocated to this specific cost area.

F. Expense for Reporting Period – Calculated figure based on the percentage(s) entered.

G. Cost Area Allocation Methodology – If allocated to multiple cost areas, an allocation method must be chosen and an allocation summary uploaded. This will be required only if there were multiple cost areas selected.

H. Business Component Allocation Methodology – After all business component cost area allocations have been completed, an expense that is allocated to multiple

business components will also require that a business component allocation method be chosen and an allocation summary uploaded.

Step 8.f. Non-Related Party Facility, Operations, Administrative and Other Direct Care Costs

This web page consists of a column for the Line Item Names and three columns for Nonrelated-Party Cost Areas and three columns for Related-Party Cost Areas, a column to Total all expenses in each line item and a column for notes. The three columns each Non-Related Party and Related Party correlate to the Program Admin & Operations and Central Office Cost Areas, plus a Total. Facility and Operations costs should be reported if the Provider owns/operates its own Residential facility and/or Day Habilitation facility or has a Program Administration office (even if that office shares space with the Residential or Day Habilitation building). Even if building/facility costs are paid by/through a central office, the portion of the building/facility and operations costs directly related to the NF contract should be reported in the specific cost area as appropriate. These cost areas are intended for the reporting of facility and operations costs that directly support the NF contract for which the accountability report is being prepared. It is important to report all costs in the correct cost area.

The first column of this web page comprises all the Facility, Operations and Administration non-staff line items. Each of these line items will be discussed in detail below. Some of the items may be reportable only in certain cost areas. Where this is the case, the accountability report will not allow entry in the cost area(s) where that type of expense may not be reported.

Cost Areas

Program Administration & Operations

The Program Administration & Operations cost area is intended to capture administrative expenses associated with direct program management of the facility itself. These are considered program administrative expenses and should be directly chargeable to the facility. There should be no allocated costs reported in the program administration cost area, with the exception of an administrator allocated from the central office.

Central Office

The Central Office cost area is intended to capture the allocated portion of shared (i.e., central office) administrative costs. For example, if documentation supports allowable legal fees directly related to the management of this facility, those legal fees should be reported in the Program Administration & Operations cost area. However, if the allowable legal fees were related to the corporation or related organization as a whole (e.g., general employee policies and procedures), the allocated portion would be reported in the Central Office cost area. If an outside accountant prepared the accountability report for the facility, the cost should be directly charged to the Program Administration & Operations cost area. If an outside accountant prepares financial statements for the parent company or sole member, the allocated portion of those costs applicable to the NF facility(s) must be reported in the Central Office cost area.

Allowable central office costs include those costs necessary for the provision of resident care for contracted services in Texas and an appropriate share of allowable indirect costs. Costs that are unallowable to the contracted provider are also unallowable as central office costs. Central office costs must be reported at the actual cost to the central office with no markup.

The Central Office cost area of the accountability report is self-contained; meaning that all allocated costs associated with the central office are reported in that cost area and should not be reported anywhere else on the accountability report. For detailed information on allocation methods for shared costs, see **Appendix B.**


8.f. Non-Related-Party Facility, Operations, Administrative and Other Direct Care Costs - Entry

Line items will accept entry into various nonrelated-party cost areas depending on the line item type. Depreciation expense does not accept direct entry because all depreciation is entered in **Step 8.e**. Certain line items are considered indirect costs only and can only be entered in the Program Administration or Central Office cost areas. All related-party facility and operations expense transactions must be entered in the appropriate Step of STAIRS and will be transferred onto this web page.

1. Rent/Lease – Building and Building Equipment
   A. Report NF building and building equipment lease/rental costs in this item.
   B. If the rental/lease of a building is from a related party, do not enter directly here. The lease and related costs must be entered in **Step 8.e.**. The calculated cost to the related party will be transferred here.
   C. If the rental/lease of building equipment is from a related party, do not enter directly here. The lease must be entered in **Step 8.b.** if the building equipment is non-depreciable (items costing less than $5,000 or with a useful life of less than one year) or **Step 8.e.** if the building equipment is depreciable (items with a cost of $5,000 or more and a useful life of more than one year).
   D. Lease deposit payments are not allowable costs at the time of payment. If the total amount of the deposit is not refunded at the specified time noted in the lease, the amount of deposit not refunded and used for allowable costs is allowable for cost-reporting purposes at that time. Lease deposits made for remodeling and purchase of replacement items/fixtures are not allowable costs at the time of payment. If the total amount of the deposit is not refunded at the specified time noted in the lease, the amount of deposit not refunded and used for allowable remodeling and purchase of replacement items/fixtures is allowable for reporting as repairs/maintenance or depreciation, whichever appropriate.
   E. Lease deposit payments made for goodwill (see **Definitions**, *Goodwill*) are not allowable costs.

2. Interest – Mortgage – See 1 TAC §355.103(b)(11). Reasonable and necessary interest on current and capital indebtedness is an allowable cost.
   A. Report the interest expense accrued from the purchase of a facility (i.e., mortgage interest) in this item. If the provider is a nonprofit entity and issued bonds for the purchase of the facility, report the bond issuance costs in this item.
   B. If a related party funded the loans, do not enter directly here. Enter through **Step 8.c.**
   C. Late payment fees and penalties are unallowable costs.
   D. Interest on vehicle loans should be reported in Transportation – Maintenance, Repairs, Gas, Oil, Interest, Insurance, Taxes, Other below.
   E. Interest on working capital loans, departmental equipment loans, loans for the purchase of building improvements, building renovations, and building equipment and other operational notes should be reported in Interest – Other below.
3. Depreciation – Building & Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, Other Amortization – Enter all buildings, building improvements, building fixed equipment, leasehold improvements, land improvements and amortizable items with a cost of $5,000 or more and a useful life of more than one year in **Step 8.e**. The calculated depreciation will be transferred here.
4. Contract Dietary Services - See 1 TAC §355.102(b)(2)(C). Report on this item the cost incurred for contract dietary services (other than those for contracted/consultant dietitians/nutritionists reported in Step 6d). Do not include the rental/lease of dietary/kitchen departmental equipment (e.g., dishwasher, freezer, ice machine, or range); those costs should be reported in item #2 above.
5. Supplies / Other Dietary Costs - Report expenses for fresh, frozen, canned or dried meats, vegetables, fruits, and beverages. Report special dietary supplements such as crackers, cookies, and other snacks. Report expenses for oral nutritional therapy food supplies such as "Ensure" or "Jevity", (these are not considered ancillary services for Medicaid accountability reporting purposes). Report any associated charges made to non-Medicaid residents for oral nutritional therapy food supplies as part of the routine daily revenues for the appropriate resident category. Report costs net of any purchase discounts, rebates, returns or allowances. If costs are not reported for food supplies in this item, please enter an explanation in the Notes box. Report in this item the nutritional supplements delivered by the total parental nutrition (TPN) systems and enteral nutrition (EN) systems were reported in item #36 above. See instructions for Schedule G. Report expenses for dishes, flatware, utensils, paper products, detergents, reference books and other resource materials used to plan meals and provide necessary nutritional services. Report costs net of any purchase discounts, rebates, returns or allowances. Non-depreciable equipment should be reported as supplies in this item. Effective for purchases made on or after the beginning date of the provider's 2004 fiscal year, non-depreciable equipment is equipment that cost less than $5,000 or has a useful life of less than one year, whereas depreciable equipment is equipment that cost $5,000 or more and has a useful life of more than one year. As well, purchases made before the provider's 2004 fiscal year that cost more than $1,000 and have a

useful life of more than one year must be depreciated using the straight-line method. For all contracted providers: for purchases made after the beginning of the contracted provider's fiscal year 2015, an asset valued at $5,000 or more and with an estimated useful life of more than one year at the time of purchase must be depreciated or amortized, using the straight-line method. In determining whether to expense or depreciate a purchased item, a contracted provider may expense any single item costing less than the capitalization level for that fiscal period as described above or having a useful life of one year or less. All depreciable equipment, whether purchased or leased from a related party or not, is to be reported in Step 8.e. Repairs and maintenance costs for dietary equipment are reported in item #7 above, regardless of the cost of the equipment. Examples of costs to be reported in this item would include costs related to the drug testing of dietary employees, physicals for dietary employees, Hepatitis B vaccinations for dietary employees, TB testing/x-rays for dietary employees, mileage reimbursement for dietary employees, and seminar costs for dietary employees. Rental of dietary equipment should be reported in item #2 above. Non-depreciable repairs and maintenance costs for dietary departmental equipment should be reported in item #10 above; depreciable repairs and maintenance costs for dietary departmental equipment should be reported in item #7 above.

Step 8.g. Facility and Operations Costs Summary

This Step provides a summary of the Related and Non-Related-Party Costs entered through **Steps 8.b.-8.f**. This view is more compact than the data entry for **Step 8.f**. The preparer may review these totals against the accountability report preparation workpapers to assure that all costs are correctly captured.


8.g. Facility and Operations Costs Summary

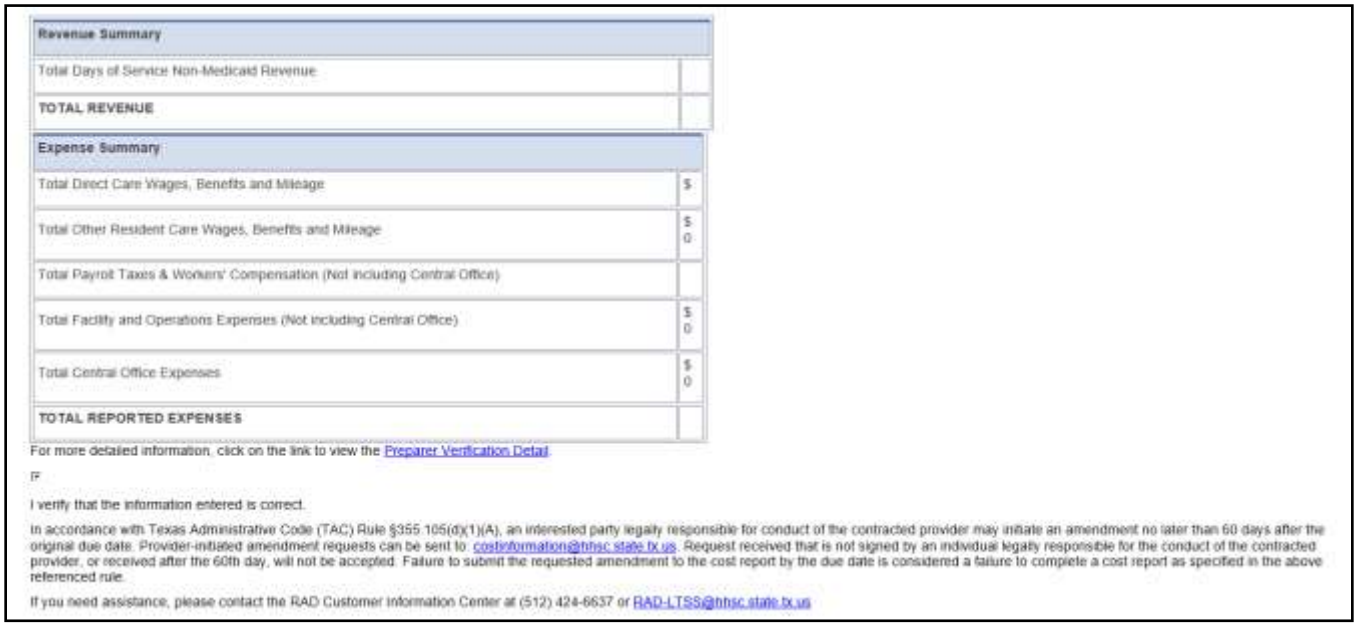
	Related and Non-Related Party Summary		
Type	Program Admin & Operations	Central Office	TOTAL
Rent / Lease - Building and Building Equipment			
Interest - Mortgage			
Depreciation - Building & Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, Other Amortization			

	Related and Non-Related Party Summary		
Type	Program Admin & Operations	Central Office	TOTAL
Contract Dietary Services			
Supplies/Other Dietary Costs			
TOTAL			

Return

Step 9. Online Verification and Submission

Preparer Verification Summary



Revenue Summary	
Total Days of Service Non-Medicaid Revenue	
TOTAL REVENUE	

Expense Summary	
Total Direct Care Wages, Benefits and Mileage	$
Total Other Resident Care Wages, Benefits and Mileage	$ 0
Total Payroll Taxes & Workers' Compensation (Not including Central Office)	
Total Facility and Operations Expenses (Not including Central Office)	$ 0
Total Central Office Expenses	$ 0
TOTAL REPORTED EXPENSES	

For more detailed information, click on the link to view the Preparer Verification Detail.

I verify that the information entered is correct.

In accordance with Texas Administrative Code (TAC) Rule §355.105(d)(1)(A), 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: costinformation@hhsc.state.tx.us. 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 cost report by the due date is considered a failure to complete a cost report as specified in the above referenced rule.

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

After all items for the accountability report have been completed, the report is ready for verification. The summary verification web page 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 and 11. Preparer Certification and Entity Contact Certification

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

A preparer may print out both the Preparer and Entity Contact Certification pages at the same time. Once one of the Certification pages is printed, the 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 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 cost report. Ultimate responsibility for the accountability report lies with the person signing as *Preparer.* If more than one person prepared the cost report, an executed Preparer Certification page (with original signature and original notary stamp/seal) may be submitted by each preparer. All persons signing the methodology certification must have attended the required cost report training.

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

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

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

PREPARER IDENTIFICATION	
Name of Contracted Provider:	
Printed/Typed Name of Signer:	Title of Signer:

_____
SIGNATURE OF PREPARER

_____
DATE

Subscribed and sworn before me, a Notary public on the _____ of _____, _____
Day *Month* *Year*

_____
Notary Signature

_____
Notary Public, State of

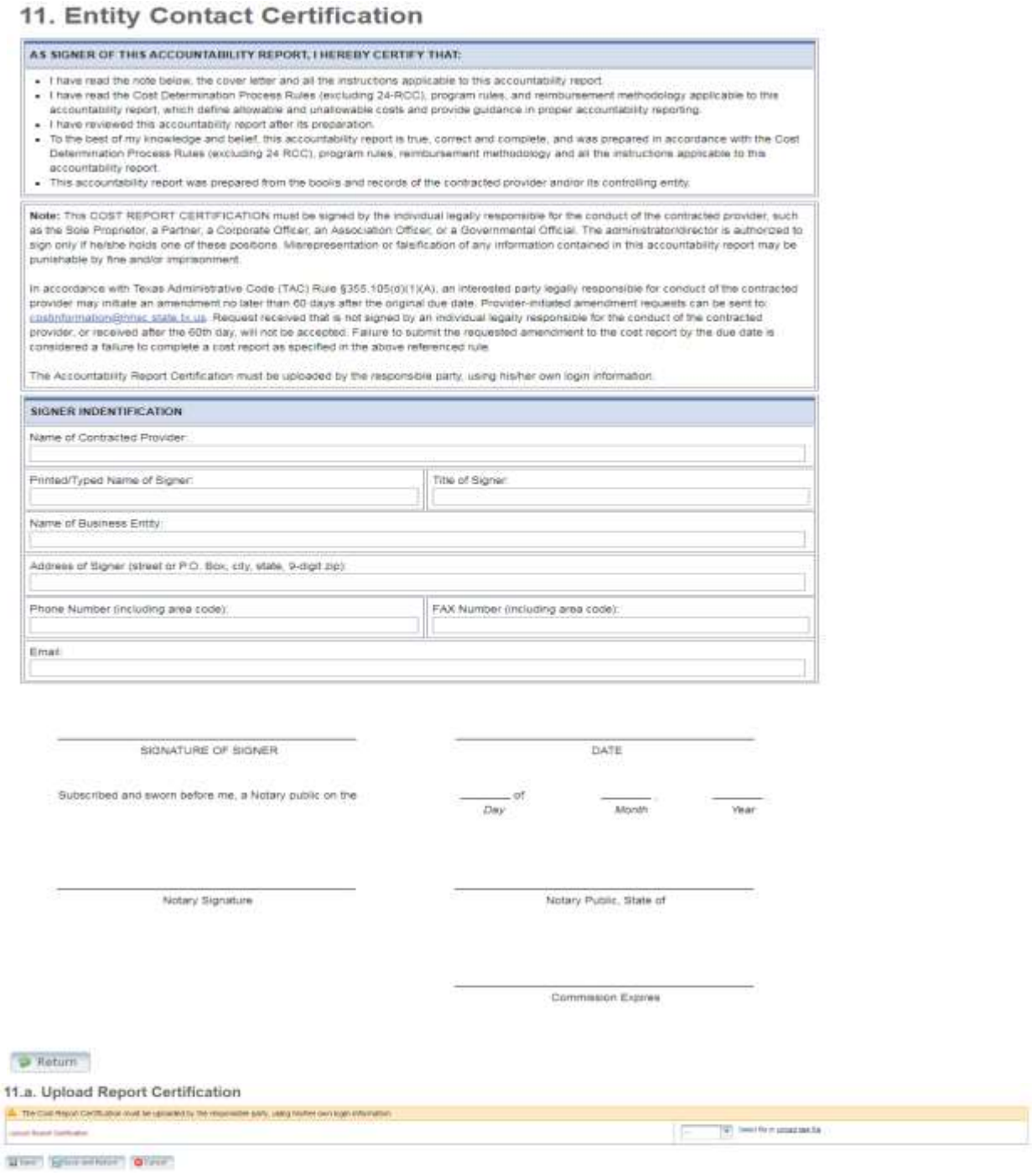
_____
Commission Expires

Save | Save and Return | Cancel

10.a. Upload Preparer Certification

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 administrator of one or more of the contracts include in the Accountability Report Group 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 Methodology Certification page, since the accountability report certification indicates that the accountability report has been reviewed after preparation.



11. Entity Contact Certification

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

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

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

In accordance with Texas Administrative Code (TAC) Rule §355.105(d)(1)(A), 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: [illegible]. 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 cost report by the due date is considered a failure to complete a cost report as specified in the above referenced rule.

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

SIGNER INDENTIFICATION

Name of Contracted Provider:

Printed/Typed Name of Signer: | Title of Signer:

Name of Business Entity:

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

Phone Number (including area code): | FAX Number (including area code):

Email:

SIGNATURE OF SIGNER | DATE

Subscribed and sworn before me, a Notary public on the _____ of _____ _____ _____
Day Month Year

Notary Signature | Notary Public, State of

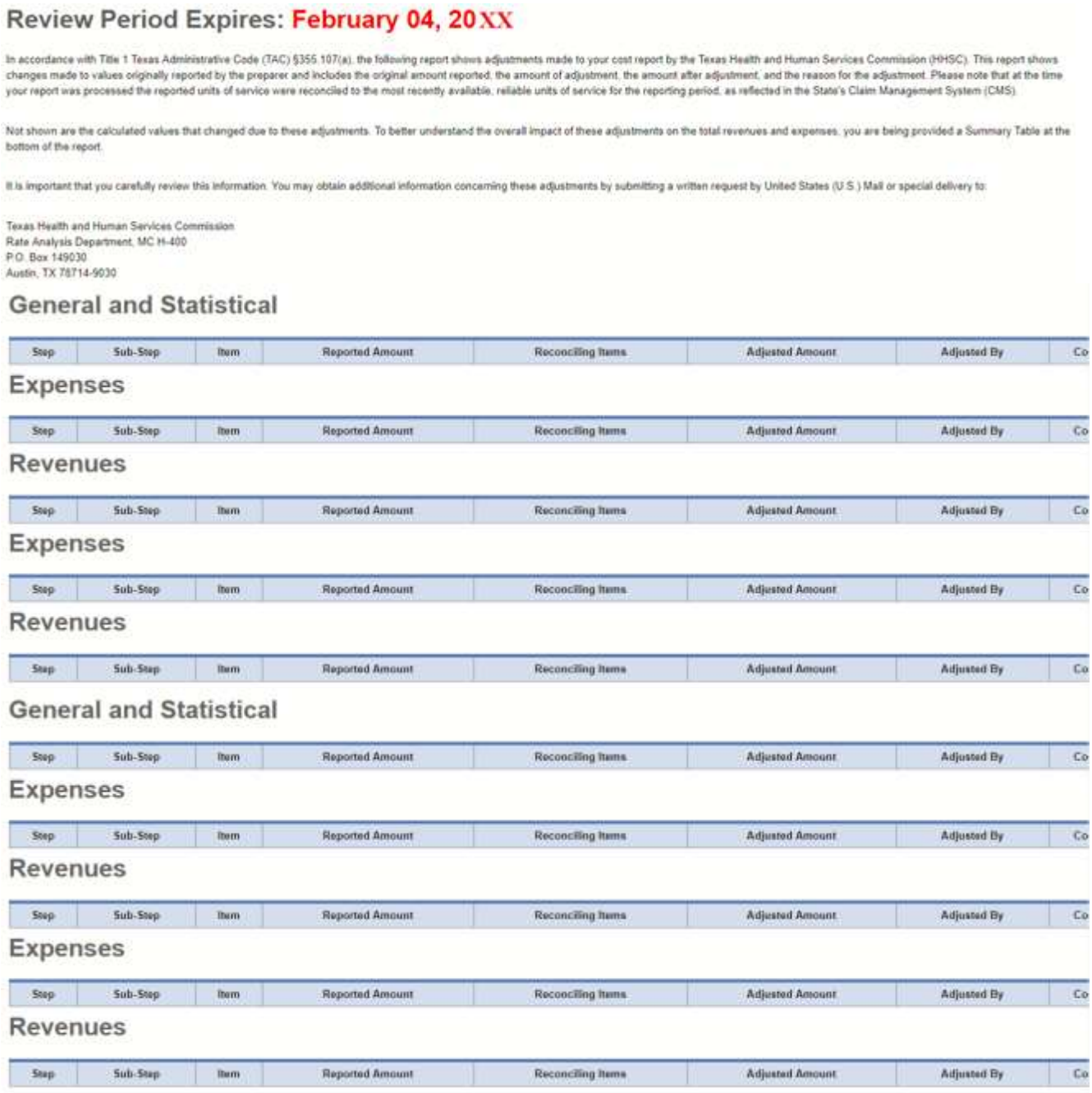
Commission Expires

Return

11.a. Upload Report Certification

Step 12. Provider Adjustment Report

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

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(a) 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	Attendant Rate	Spending Requirement	Actual Spending	Per Unit Recoupment	Estimated Total Recoupment
PHC PRIORITY	$0.00	$0.00	$0.00	$0.00	$0.00
PHC NON-PRIORITY	$0.00	$0.00	$0.00	$0.00	$0.00
Total Recoupment	$0.00	$0.00	$0.00	$0.00	$0.00

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.

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

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

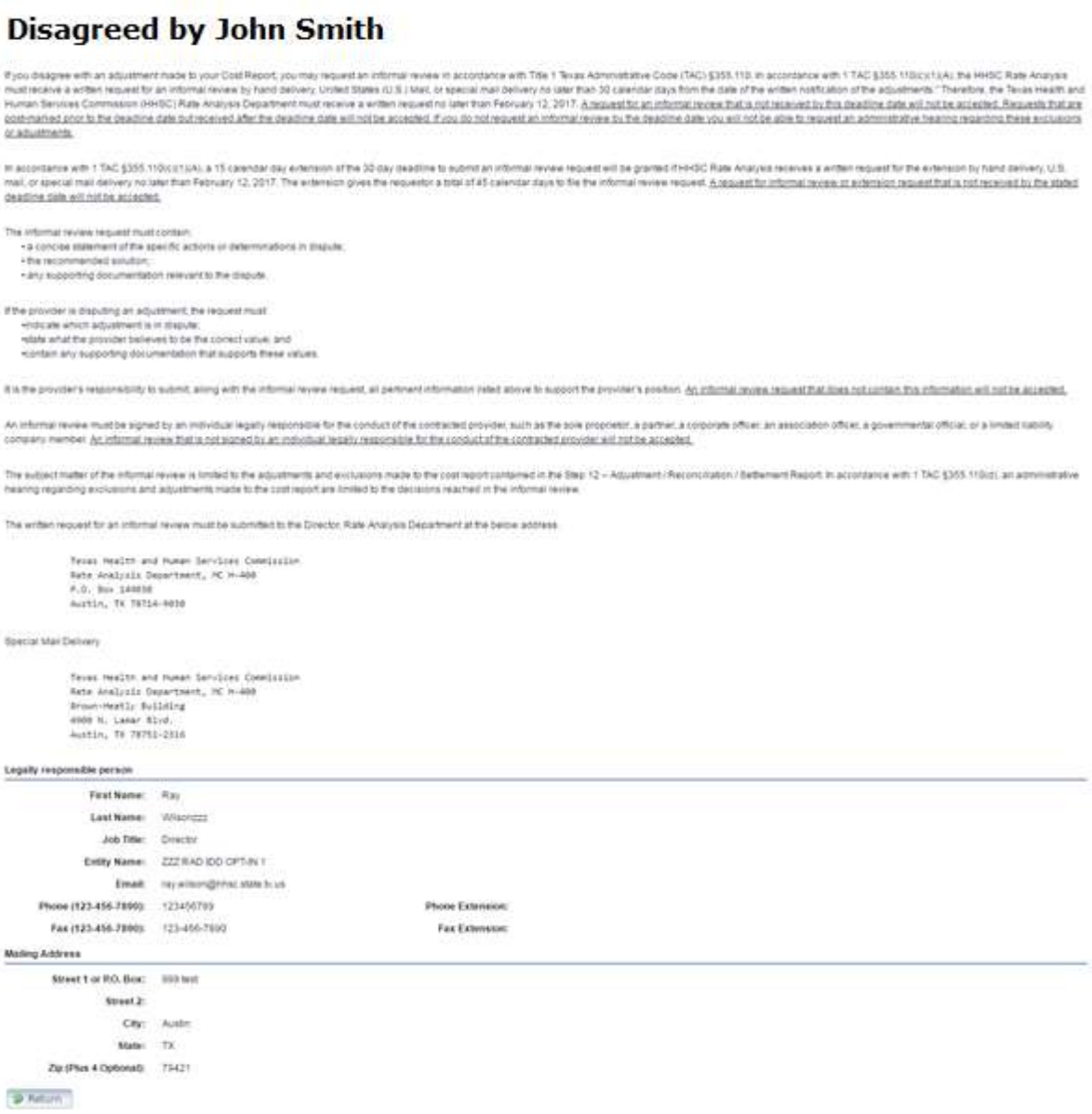
Special Mail Delivery:
Texas Health and Human Services Commission
Rate Analysis Department, MC H-400
Brown-Heatly Building
4900 N. Lamar Blvd.
Austin, TX 78751-2316

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.

Step 13. Agree/Disagree



Disagreed by John Smith

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

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

The informal review request must contain:
- a concise statement of the specific actions or determinations in dispute;
- the recommended solution;
- any supporting documentation relevant to the dispute.

If the provider is disputing an adjustment, the request must:
- indicate which adjustment is in dispute;
- state what the provider believes to be the correct value; and
- contain any supporting documentation that supports these values.

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

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

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

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

Texas Health and Human Services Commission
Rate Analysis Department, 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

Legally responsible person

First Name:	Ray		
Last Name:	Wilsonzzz		
Job Title:	Director		
Entity Name:	ZZZ RAD IDD OPT-IN 1		
Email:	ray.wilson@hhsc.state.tx.us		
Phone (123-456-7890):	1234567890	**Phone Extension:**	
Fax (123-456-7890):	123-456-7890	**Fax Extension:**	

Mailing Address

Street 1 or P.O. Box:	999 test
Street 2:	
City:	Austin
State:	TX
Zip (Plus 4 Optional):	78421

Return

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 accountability 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 Accountability Report Group number or Contract number of the report
- Includes the year and type of report (Accountability Report 2020, 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

Summary Table

Revenue Summary	Total as Submitted	Adjustments	Total After Adjustments
Total Assessment Revenue	$0.00	$0.00	$0.00
Total STAR+PLUS Revenue	$2,864,563.00	$0.00	$2,864,563.00
Total Requisition Fee Revenue	$0.00	$0.00	$0.00
Total Private and Other Revenue	$0.00	$1.00	$1.00
Total	**$2,864,563.00**	**$1.00**	**$2,864,564.00**

Expense Summary	Total as Submitted	Adjustments	Total After Adjustments
Total Attendant Wages, Benefits and Mileage	$2,134,994.00	$5,786.00	$2,140,780.00
Total Non-Attendant Wages, Benefits and Mileage	$0.00	$0.00	$0.00
Total Administrative and Operations Wages, Benefits and Mileage (less Central Office)	$256,660.00	$0.00	$256,660.00
Total Payroll Taxes & Workers' Compensation (Not including Central Office)	$288,893.00	($7,814.00)	$281,079.00
Total Facility and Operations Expenses (Not including Central Office)	$113,188.73	$0.00	$113,188.73
Total Central Office Expenses	$314,851.00	$7,814.00	$322,665.00
Total	**$3,108,586.73**	**$5,786.00**	**$3,114,372.73**

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.

On STEP 2 of this cost report you indicated 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. As a result, 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 this aggregation.

Recoupment Summary

Edit Recoupment

Program / Contract / Group	Attendant Rate	Spending Requirement	Actual Spending	Per Unit Recoupment	Estimated Total Recoupment
PHC Priority	$10.37	$9.33	$14.21	$0.00	$0.00
PHC NonPriority	$9.61	$8.65	$9.29	$0.00	$0.00
Total Recoupment		$17.98	$23.50	$0.00	$0.00

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(k) or §355.112(l) 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 Texas Department of Aging and Disability Services (DADS), Provider Claims Services for processing after the "Review Period Expires" date shown above and below. Do not send checks or payments to DADS or HHSC unless specifically instructed by DADS. 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 (faxes and e-mails 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, 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

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 web page in STAIRS. The Upload Center itself can be located in STAIRS on the Dashboard through clicking on Manage, to the far right on the header.

Appendix B. Allocation Methodologies

Units of Service: This allocation method can only be used for shared costs where the services have equivalent units of equivalent service and MUST be used where that is the case. An equivalent unit means the time of a service is important: a Nursing Facility (NF) and a DAHS facility both provide a "Day" of service, but one is a 24-hour "Day" while the other is not. An equivalent service means that the activities provided by staff are essentially the same.
Cost-to-Cost: If allocations based on units of service are not acceptable, and all of a provider's contracts are labor-intensive, or if all contracts have programmatic or residential building costs, the provider may choose to allocate their indirect shared costs on a cost-to-cost basis.

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

- Salaries/wages
- Contracted labor (excluding consultants)

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

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

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

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

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

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

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

Functional: If the provider has any doubt whether the functional method used is in accordance with applicable rules or requires prior written approval from the Provider Finance Department, send email to RAD-LTSS@hhsc.state.tx.us 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 RAD-LTSS@hhsc.state.tx.us 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.

Table 1 below provides a summary of appropriate allocation methods for various situations. For questions regarding proper allocation of shared costs, please contact the Provider Finance Department's Customer Service Center at RAD-LTSS@hhsc.state.tx.us.

TABLE 1. APPROPRIATE ALLOCATION METHODS FOR REPORTING SHARED ADMINISTRATIVE COSTS THAT CANNOT BE REASONABLY DIRECT COSTED

Makeup of Controlling Entity's Business Components	Multiple Contracts of the Same (Equivalent) Type of Service	Various Business Components - All Labor-Intensive	Various Business Components - All with Programmatic- or Residential-Building Costs	Mixed Business Components - Some with Programmatic- or Residential-Building Costs and Some Labor-Intensive	Shared Administrative Personnel Performing Different Duties for Different Business Components (not in Direct Care)	Functional Methods
Allowable Allocation Methods	Units of Service	Cost-to-Cost Labor Costs Salaries **Not applicable to NF providers**	Cost-to-Cost Total-Cost-Less-Facility-Cost^ Labor Costs Salaries	Total-Cost-Less-Facility-Cost^ Labor Costs	Time Study*	Payroll Department - Number of payroll checks issued for each business component during the reporting period Purchasing Department - Number of purchase orders processed during the reporting period for each business component

Providers may use any of the methods listed as appropriate for the makeup of their business organization. If one of the approved methods does not provide a reasonable reflection of the provider's actual operations, the provider must use a method that does. If none of the listed methods provides a reasonable reflection of the provider's actual operations, contact the Provider Finance for further instructions.

* See 1 TAC §355.105(b)(2)(B)(i) for time study requirements.

^ When using 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

Allocation Summary - **UNITS of SERVICE**

Adjusted Trial Balance - Healthy Care Provider, Inc.
As of 12/31/20XX

						Allocated Shared Costs			
			Direct Costs		Shared	55.69%	44.31%	Line Item	
Expenses:	Total Costs	Disallowed	NF 1	NF 2	Costs	NF 1	NF 2	NF 1	NF 2
Salaries									
Direct Care Nursing Staff	125,347.28				125,347.28	69,805.90	55,541.38	xxx	xxx
Dietary Staff	45,288.47		25,361.54	19,926.93	-	-	-	xxx	xxx
Administrative Staff	33,254.88		25,458.97	7,795.91	-	-	-	xxx	xxx
Housekeeping Staff	82,588.92		51,205.13	31,383.79	-	-	-	xxx	xxx
Contracted RN	65,000.00				65,000.00	36,198.50	28,801.50	xxx	xxx
FICA/Medicare	21,915.69		7,804.96	4,521.66	9,589.07	5,340.15	4,248.92	xxx	xxx
State & Federal Unemployment	5,156.63		1,270.51	554.46	3,331.66	1,855.40	1,476.26	xxx	xxx
Workers's Compensation	0.00		0.00	0.00	-	-	-	xxx	xxx
Employee Benefits/Insurance	4,847.25		1,254.01	889.47	2,703.77	1,505.73	1,198.04	xxx	xxx
Office Lease	9,000.00		2,400.00	2,100.00	4,500.00	2,506.05	1,993.95	xxx	xxx
Utilities	8,945.67		2,385.51	2,087.32	4,472.84	2,490.92	1,981.91	xxx	xxx
Telecommunications	3,008.16		401.68	333.75	2,272.73	1,265.68	1,007.05	xxx	xxx
Office Supplies	1,501.80				1,501.80	836.35	665.45	xxx	xxx
Medical Supplies	874.64				874.64	487.09	387.55	xxx	xxx
Insurance - General Liability	1,254.00				1,254.00	698.35	555.65	xxx	xxx
Insurance - Malpractice	1,050.87				1,050.87	585.23	465.64	xxx	xxx
Travel	387.98	237.65	54.36	35.74	60.23	33.54	26.69	xxx	xxx
Advertising	402.87	104.97			297.90	165.90	132.00	xxx	xxx
Miscellaneous	601.47	254.74			346.73	193.09	153.64	xxx	xxx
Totals	410,426.58	597.36	117,596.68	69,629.03	222,603.51	123,967.90	98,635.62		

Units of Service Allocation Percentages:	Units of Service	Percentage
Total Healthy Care Units NF 1	9,961	55.69%
Total Healthy Care Units NF 2	7,924	44.31%
	17,885	100.00%

Allocation Summary - **LABOR COST METHOD**

Adjusted Trial Balance - Healthy Care Provider , Inc.
As of 12/31/20XX

			Direct Costs			Shared	Allocated Shared Costs 43.04%	30.36%	26.60%	Line Item		
Expenses:	Total Costs	Disallowed	NF1	NF2	Home Health	Costs	NF1	NF2	Home Health	NF1	NF2	Home Health
Salaries												
Direct Care Staff	125,347.28					125,347.28	53,949.47	38,055.43	33,342.38	xxx	xxx	xxx
Dietary Staff	87,434.22		87,434.22			-	-	-	-	xxx	xxx	xxx
Housekeeping Staff	65,238.41			65,238.41		-	-	-	-	xxx	xxx	xxx
Physical Therapists	54,975.15				54,975.15	-	-	-	-	xxx	xxx	xxx
Supervisors	33,254.88		13,528.48	9,467.85	10,258.55	-	-	-	-	xxx	xxx	xxx
Maintenance Staff	4,572.08	Labor	4,572.08			-	-	-	-	xxx	xxx	xxx
CPR Instructor	2,500.00	Costs				2,500.00	1,076.00	759.00	665.00	xxx	xxx	xxx
FICA/Medicare	28,018.12		8,073.41	5,715.03	4,990.38	9,239.30	3,976.59	2,805.05	2,457.65	xxx	xxx	xxx
State & Federal Unemployme	6,592.50		2,524.07	1,494.13	978.51	1,595.79	686.83	484.48	424.48	xxx	xxx	xxx
Employee Benefits/Insurance	4,847.25		1,254.01	889.47	1,358.41	1,345.36	579.04	408.45	357.87	xxx	xxx	xxx
Workers' Compensation	0.00					-	-	-	-	xxx	xxx	xxx
Office Lease	9,000.00		2,400.00	2,100.00	2,500.00	2,000.00	860.80	607.20	532.00	xxx	xxx	xxx
Utilities	8,945.67		2,385.51	2,087.32	2,484.91	1,987.93	855.61	603.54	528.79	xxx	xxx	xxx
Telecommunications	3,008.16		401.68	333.75	554.37	1,718.36	739.58	521.69	457.08	xxx	xxx	xxx
Office Supplies	1,501.80					1,501.80	646.37	455.95	399.48	xxx	xxx	xxx
Medical Supplies	874.64				487.39	387.25	166.67	117.57	103.01	xxx	xxx	xxx
Insurance - Malpractice	1,050.87					1,050.87	452.29	319.04	279.53	xxx	xxx	xxx
Travel	387.98	204.65	54.36	35.74	84.97	8.26	3.56	2.51	2.20	xxx	xxx	xxx
Advertising	402.87	104.97				297.90	128.22	90.44	79.24	xxx	xxx	xxx
Miscellaneous	601.47	254.74				346.73	149.23	105.27	92.23	xxx	xxx	xxx
Totals	438,553.35	564.36	122,627.82	87,361.70	78,672.64	149,326.83	64,270.27	45,335.63	39,720.94			

Labor Method Allocation Percentages:	Labor Costs	Percentage
Total Healthy Care NF1	117,386.27	43.04%
Total Healthy Care NF2	82,804.89	30.36%
Total Healthy Care Home Health	72,561.00	26.60%

Allocation Summary - **TOTAL COST LESS FACILITY COST**

Adjusted Trial Balance - Healthy Care Provider, Inc.
As of 12/31/20XX

			Direct Costs			Allocated Shared Costs			
				Adult Day Care	Shared	57.22%	42.78%	Line Item	
Expenses:	Total Costs	Disallowed	NF1	DAHS	Costs	NF1	DAHS	NF1	DAHS
Salaries									
Administrative	125,347.28				125,347.28	71,723.71	53,623.57	xxx	xxx
Direct Care Staff	87,434.22		87,434.22		-	-	-	xxx	xxx
Adult Day Care Attendants	33,254.88			33,254.88	-	-	-	xxx	xxx
Adult Day Care Drivers	25,492.12			25,492.12	-	-	-	xxx	xxx
Contracted Nurse	9,482.66			9,482.66	-	-	-	xxx	xxx
FICA/Medicare	18,821.78		8,843.84	5,219.57	4,758.37	2,722.74	2,035.63	xxx	xxx
State & Federal Unemployment	4,428.65		2,822.33	665.10	941.23	538.57	402.66	xxx	xxx
Employee Benefits/Insurance	4,847.25		1,254.01	889.47	2,703.77	1,547.10	1,156.67	xxx	xxx
Office Lease	9,000.00		2,400.00	2,100.00	4,500.00	2,574.90	1,925.10	xxx	xxx
Utilities	8,945.67	Facility	2,385.51	2,087.32	4,472.84	2,559.36	1,913.48	xxx	xxx
Ad Valorem Taxes	3,256.88	Costs	842.64	1,834.64	579.60	331.65	247.95	xxx	xxx
Maintenance & Repairs	1,846.74		246.25	1,041.67	558.82	319.76	239.06	xxx	xxx
Telecommunications	3,008.16		401.68	333.75	2,272.73	1,300.46	972.27	xxx	xxx
Office Supplies	1,501.80				1,501.80	859.33	642.47	xxx	xxx
Medical Supplies	874.64				874.64	500.47	374.17	xxx	xxx
Insurance - General Liability	1,254.00				1,254.00	717.54	536.46	xxx	xxx
Insurance - Malpractice	1,050.87				1,050.87	601.31	449.56	xxx	xxx
Travel	387.98	237.65	54.36	35.74	60.23	34.46	25.77	xxx	xxx
Advertising	402.87	104.97			297.90	170.46	127.44	xxx	xxx
Miscellaneous	601.47	254.74			346.73	198.40	148.33	xxx	xxx
Totals	341,239.93	597.36	106,684.84	82,436.92	151,520.81	86,700.21	64,820.60		

Total Costs-Less-Facility-Costs Allocation Percentages:

	NF1	DAHS	Totals
Total Healthy Care Costs	106,684.84	82,436.92	189,121.76
Total Healthy Care Facility Costs	5,874.40	7,063.63	12,938.03
Total Healthy Care Costs Less Facility Costs	100,810.44	75,373.29	176,183.73

Allocation Summary - COST-TO-COST

Adjusted Trial Balance - Healthy Care Provider, Inc.
As of 12/31/20XX

							Allocated Shared Costs					
				Direct Costs		Shared	41.48%	30.72%	27.80%		Line Item	
Expenses:	Total Costs	Disallowed	NF1	DAHS	PHC	Costs	NF1	DAHS	PHC	NF1	DAHS	PHC
Salaries												
Administrative	125,347.28					125,347.28	51,994.05	38,506.68	34,846.54	xxx	xxx	xxx
CBA Attendants	87,434.22		87,434.22			-	-	-	-	xxx	xxx	xxx
CLASS Habilitation Attendants	65,238.41			65,238.41		-	-	-	-	xxx	xxx	xxx
PHC Attendants	54,975.15				54,975.15	-	-	-	-	xxx	xxx	xxx
Supervisors	33,254.88		13,528.48	9,467.85	10,258.55	-	-	-	-	xxx	xxx	xxx
Speech Therapists	249.85		249.85			-	-	-	-	xxx	xxx	xxx
CPR Instructor	2,500.00					2,500.00	1,037.00	768.00	695.00	xxx	xxx	xxx
FICA/Medicare	28,018.12		7,723.65	5,715.03	5,009.49	9,569.95	3,969.62	2,939.89	2,660.45	xxx	xxx	xxx
State & Federal Unemployment	6,592.50		2,524.07	1,494.13	978.51	1,595.79	661.93	490.23	443.63	xxx	xxx	xxx
Employee Benefits/Insurance	4,847.25		1,254.01	889.47	1,358.41	1,345.36	558.06	413.29	374.01	xxx	xxx	xxx
Office Lease	9,000.00		2,400.00	2,100.00	2,500.00	2,000.00	829.60	614.40	556.00	xxx	xxx	xxx
Utilities	8,945.67		2,385.51	2,087.32	2,484.91	1,987.93	824.59	610.69	552.64	xxx	xxx	xxx
Telecommunications	3,008.16		401.68	333.75	554.37	1,718.36	712.78	527.88	477.70	xxx	xxx	xxx
Office Supplies	1,501.80					1,501.80	622.95	461.35	417.50	xxx	xxx	xxx
Medical Supplies	874.64				874.64	-	-	-	-	xxx	xxx	xxx
Insurance - General Liability	1,254.00					1,254.00	520.16	385.23	348.61	xxx	xxx	xxx
Insurance - Malpractice	1,050.87					1,050.87	435.90	322.83	292.14	xxx	xxx	xxx
Travel	387.98	204.65	54.36	35.74	84.97	8.26	3.43	2.54	2.30	xxx	xxx	xxx
Advertising	402.87	104.97				297.90	123.57	91.51	82.82	xxx	xxx	xxx
Miscellaneous	601.47	254.74				346.73	143.82	106.52	96.39	xxx	xxx	xxx
Totals	435,485.12	564.36	117,955.83	87,361.70	79,079.00	150,524.23	62,437.45	46,241.04	41,845.74			

Cost-to-Cost Allocation Percentages:	Total Costs	Percentage
Total Healthy Care NF1	117,955.83	41.48%
Total Healthy Care DAHS	87,361.70	30.72%
Total Healthy Care PHC	79,079.00	27.80%

Allocation Summary - **SALARIES METHOD**

Adjusted Trial Balance - Healthy Care Provider, Inc.
As of 12/31/20XX

			Direct Costs				Allocated Shared Costs			Line Item		
Expenses:	Total Costs	Disallowed	NF1	NF2	DAHS	Shared Costs	22.87% NF1	50.59% NF2	26.54% DAHS	Lake NF1	River NF2	Ocean DAHS
Salaries												
Administrative	125,347.28					125,347.28	28,666.92	63,413.19	33,267.17	xxx	xxx	xxx
Direct Care Staff	87,434.22		19,286.35	46,289.32	21,858.55	-	-	-	-	xxx	xxx	xxx
Drivers	44,295.84		10,352.45	22,576.36	11,367.03	-	-	-	-	xxx	xxx	xxx
Housekeeping Staff	54,975.15	Salary	12,094.53	29,136.83	13,743.79	-	-	-	-	xxx	xxx	xxx
Contracted RN	70,000.00		15,299.99	28,145.20	19,221.57	7,333.24	1,677.11	3,709.89	1,946.24	xxx	xxx	xxx
Dietitian	2,400.00					2,400.00	548.88	1,214.16	636.96	xxx	xxx	xxx
FICA/Medicare	28,018.12		7,723.65	5,715.03	5,009.49	9,569.95	2,188.65	4,841.44	2,539.86	xxx	xxx	xxx
State & Federal Unemployment	6,592.50		2,524.07	1,494.13	978.51	1,595.79	364.96	807.31	423.52	xxx	xxx	xxx
Employee Benefits/Insurance	4,847.25		1,254.01	889.47	1,358.41	1,345.36	307.68	680.62	357.06	xxx	xxx	xxx
Office Lease	9,000.00		2,400.00	2,100.00	2,500.00	2,000.00	457.40	1,011.80	530.80	xxx	xxx	xxx
Utilities	8,945.67		2,385.51	2,087.32	2,484.91	1,987.93	454.64	1,005.69	527.60	xxx	xxx	xxx
Telecommunications	3,008.16		401.68	333.75	554.37	1,718.36	392.99	869.32	456.05	xxx	xxx	xxx
Office Supplies	1,501.80					1,501.80	343.46	759.76	398.58	xxx	xxx	xxx
Medical Supplies	874.64				487.39	387.25	88.56	195.91	102.78	xxx	xxx	xxx
Insurance - General Liability	1,254.00					1,254.00	286.79	634.40	332.81	xxx	xxx	xxx
Insurance - Malpractice	1,050.87					1,050.87	240.33	531.64	278.90	xxx	xxx	xxx
Travel	387.98	204.65	54.36	35.74	84.97	8.26	1.89	4.18	2.19	xxx	xxx	xxx
Advertising	402.87	104.97				297.90	68.13	150.71	79.06	xxx	xxx	xxx
Miscellaneous	601.47	254.74				346.73	79.30	175.41	92.02	xxx	xxx	xxx
Totals	450,937.82	564.36	73,776.60	138,803.15	79,648.99	158,144.72	36,167.70	80,005.41	41,971.61			

Salary Method Allocation Percentages:	Salary Costs	Percentage
Total Healthy Care NF1	57,033.32	22.87%
Total Healthy Care NF2	126,147.71	50.59%
Total Healthy Care DAHS	66,190.94	26.54%

Appendix C - Allocation of Shared Dietary/Central Kitchen

Allocation of Shared Dietary/Central Kitchen Expenses

A central kitchen is defined as a kitchen that provides meals and/or snacks to more than one contract, program, or business entity. If the provider has a central kitchen that prepares meals for more than one business entity or program, do not report the expense of the meals provided for this entity as a single entry on the accountability report. Shared dietary/central kitchen expenses must be reported on the accountability report in the various items that reflect the types of expense (i.e. building depreciation, salaries, food, food service supplies).

Shared dietary/central kitchen costs include dietary staff costs, food costs, nonfood supplies, contracted dietary services, kitchen building costs (including depreciation/lease, maintenance costs, utilities, insurance, and other facility costs allocable to the kitchen area), and kitchen departmental equipment costs (including non-depreciable purchases, depreciation, rental/lease costs, and repairs/maintenance costs). If the dining room is also shared, then the dining room costs (i.e., staff, building, and departmental equipment) must also be properly allocated.

If dietary staff work in positions other than the kitchen area, the time spent working in each function must be documented and properly reported using continuous, daily timesheets. The non-dietary staff costs must be first removed before applying an allocation method to the shared dietary/central kitchen costs.

Allocation of these expenses must be accompanied by a detailed allocation summary. Accountability reports that are submitted without the required detailed summaries will not be considered acceptable and will be returned for proper completion. (Refer to 1 TAC §355.102(j) and 1 TAC §355.105(b)(2)(B)(v))

Central kitchen costs can be allocated based on one of three functional allocation methods:

- Number of meals provided;
- The weighted number of meals provided; or
- Central kitchen allocation methodology guidelines.

Number of Meals Provided Allocation Method

All shared dietary/central kitchen costs can be allocated by the number of meals provided allocation method if the central kitchen:

1. Prepares meals for only one Medicaid program (e.g. NF); and
2. Provides the same meal service to all the contracts in that Medicaid program,such as:
    A. Breakfast, lunch, dinner and two snacks to all NF contracts, or
    B. Breakfast, lunch and dinner to all NF contracts, or
    C. Breakfast, lunch, dinner and one snack to all NF contracts.

There are certain situations where using the number of meals provided as an allocation basis for central kitchen expenses is not appropriate. The following situations are examples where the number of meals provided is **not** an acceptable allocation method:

A central kitchen provides meals to different types of Medicaid programs. For example:

a. The central kitchen provides meals to an ICF/IID component and to a Nursing Facility contract; or
b. The central kitchen provides meals to multiple components/contracts of the same Medicaid program, but some of the components/contracts receive breakfast, lunch, dinner and two snacks, and other components/contracts receive only lunch and dinner and one snack, or breakfast, lunch and dinner and no snacks.

When the meals service is not the same and dietary care services are shared by more than one business component (e.g., ICF/IID, NF, child day care, and/or hospital), the shared dietary costs must be properly allocated using <u>either</u> of the following allocation methods:

- The Weighted Number of Meals Provided Allocation Method or
- The Central Kitchen Allocation Methodology Guidelines

Weighted Number of Meals Provided Allocation Method

The "weighted number of meals provided" method of allocating meal costs uses United States Department of Agriculture (USDA) Child and Adult Care Food Program meals patterns and child-to-adult meals ratios to develop weights for each type of meal (i.e., breakfast, lunch, dinner, and snack) for different age groups (i.e., children ages 3 to 5, children ages 6 to 12, and adults). These weights can then be used to determine the proportion of total weighted meals provided by the central kitchen to each age group and to each NF contract. By multiplying the proportion of total weighted meals provided to the NF contract for which the accountability report preparer is completing the accountability report by the various central kitchen costs, the accountability report preparer can determine the central kitchen costs which should be reported on this accountability report.

The weights for each meal type for each age group are calculated by multiplying the child-to-adult ratio for the age group and meal type by the Recommended Daily Allowance (RDA) weight for the age group and meal type. These weights are calculated in Tables 1 – 3 below followed by examples of the calculation of ratios for meals served only to adults with different meal service (Example 1) and the calculation of ratios for meals served to both adults and children (Example 2).

Table 1. Meal Weights for Children Ages 3 to 5.

Meal Type	Child-to-Adult Ratio		RDA Weight		Meal Weight
Breakfast	0.6667	X	0.75	=	0.5000
Lunch	0.5625	X	1.00	=	0.5625
Snack	0.7500	X	0.50	=	0.3750
Supper	0.5625	X	1.00	=	0.5625

Table 2. Meal Weights for Children Ages 6 to 12.

Meal Type	Child-to-Adult Ratio		RDA Weight		Meal Weight
Breakfast	0.8333	X	0.75	=	0.6250
Lunch	0.8125	X	1.00	=	0.8125
Snack	1.2500	X	0.50	=	0.6250
Supper	0.8125	X	1.00	=	0.8125

Table 3. Meal Weights for Adults.

Meal Type	Child-to-Adult Ratio		RDA Weight		Meal Weight
Breakfast	1.00	X	0.75	=	0.75
Lunch	1.00	X	1.00	=	1.00
Snack	1.00	X	0.50	=	0.50
Supper	1.00	X	1.00	=	1.00

Example 1. The Weighted Number of Meals Provided Allocation Method - Calculation of Ratios for Meals Served Only to Adults with Different Meal Service (This allocation method is to be used when a central kitchen serves only adults.)

A central kitchen provides meals to an NF and a DAHS program which both serve only adults. The provider-maintained meal counts on both programs.

DAHS	RDA Weight	Meal Count	Weighted Meal Count (rounded to 2 decimals)
Morning Snack	0.5	15,621	7,810.50
Lunch	1	15,608	15,608.00
Afternoon Snack	0.5	14,527	7,263.50
Total weighted meals			30,682.00

NF	RDA Weight	Meal Count	Weighted Meal Count (rounded to 2 decimals)
Breakfast	0.75	7,851	5,888.25
Lunch	1	7,803	7,803.00
Morning Snack	0.5	7,474	3,737.00
Dinner	1	6,352	6,352.00
Afternoon Snack	0.5	6,498	3,249.00
Total weighted meals			27,029.25

Allocation percentage based on the weighted meals count.

	Weighted Meals Count	Percentage for Allocation
DAHS	30,682.00	53.16%
NF	27,029.25	46.84%
Total	57,711.25	100.00%

Allocation of Shared Dietary Expenses	Total	DAHS	NF
Central kitchen costs to be allocated:	100.00%	53.16%	46.84%
Raw food costs	$94,934.70	$50,467.29	$44,467.41
Cook Salary	$17,680.00	$9,398.69	$8,281.31
Assistant Salary	$10,712.00	$5,694.50	$5,017.50
Building Rent	5,993.20	$3,185.99	$2,807.21
Building Insurance	$1,020.26	$542.37	$477.89
Utilities	$3,049.66	$1,621.20	$1,428.46
Pest Control	$151.44	$80.51	$70.93
Equipment	$55.30	$29.40	$25.90
Non-Food Supplies	$295.68	$157.18	$138.50
Total central kitchen costs to be allocated:	$133,892.24	$71,183.38	$62,708.86

Example 2. The Weighted Number of Meals Provided Allocation Method - Calculation of Ratios of Meals Served to Both Adults and Children (This allocation method is to be used when a central kitchen serves both children and adults).

A central kitchen provides meals to three different programs: a day care that serves children3-5 years old; a day care that serves to children 6-12 years old; and a NF that serves only adults. The provider kept meal counts on each of the three programs.

a. Total Meal Count

	Day Care 3-5 yrs. old	Day Care 6-12 yrs. old	NF Adults
Breakfast	5,200	3,900	0
Snack	0	0	7,800
Lunch	5,200	3,900	7,800
Snack	5,200	3,120	6,500
Dinner	5,200	0	0

b. Weighted Meal Count for Day Care (3-5 yrs. old)

	Meal Weight	Meal Count	Wtd. Meal Count*
Breakfast	0.5000	5,204	2,602.00
Snack	0.3750	0	0.00
Lunch	0.5625	5,200	2,925.00
Snack	0.3750	5,200	1,950.00
Supper	0.5625	5,200	2,925.00

c. Weighted Meal Count for Day Care (6-12 yrs. old)

	Meal Weight	Meal Count	Wtd. Meal Count*
Breakfast	0.620	3,900	2,438.00
Snack	0.6250	0	0.00
Lunch	0.8125	3,900	3,168.75
Snack	0.6250	3,120	1,950.00
Dinner	0.8125	0	0.00

Total	10,402.00

Total			7,556.75

d. Weighted Meal Count for NF (Adults)

	Meal Weight	Meal Count	Wtd. Meal Count*
Breakfast	0.75	0	0.00
Snack	0.5	7,800	3,900.00
Lunch	1	7,800	7,800.00
Snack	0.5	6,500	3,250.00
Dinner	1	0	0.00
Total			14,950.00

* = rounded to two decimal places.

e. Allocation percentage based on the weighted meal count

Program	Wtd Meal Count	% for Allocation
Day Care (3-5 yrs. old)	10,402.00	31.61%
Day Care (6-12 yrs. old)	7,556.75	22.96%
NF	14,950.00	45.43%
TOTAL	32,908.75	100.00%

f. Allocation of Shared Dietary Expenses

Central kitchen costs to be allocated:	Total 100.00%	3-5 yrs. 31.61%	6-12 yrs. 22.96%	NF 45.43%
Raw food costs	$94,934.70	$30,008.86	$21,797.01	$43,128.83
Cook Salary	$17,680.00	$5,588.65	$4,059.33	$8,032.02
Assistant Salary	$10,712.00	$3,386.06	$2,459.48	$4,866.46
Building Rent	5,993.20	$1,894.45	$1,376.04	$2,722.71
Building Insurance	$1,020.26	$322.50	$234.25	$463.50
Utilities	$3,049.66	$964.00	$700.20	$1,385.46
Pest Control	$151.44	$47.87	$34.77	$68.80
Equipment	$55.30	$17.48	$12.70	$25.12
Non-Food Supplies	$295.68	$93.46	$67.89	$134.33
Total Central kitchen costs to be allocated:	$133,892.24	$42,323.34	$30,741.66	$60,827.24

Central Kitchen **Allocation** Method

All shared dietary/central kitchen costs can be allocated by the Central Kitchen Allocation Method if the provider believes that this method gives a more accurate picture of the true allocation of their central kitchen costs then either the Number of Meals Provided Allocation Method (if appropriate) and the Weighted Number of Meals Provided Allocation Method.

Section 1-Introduction

The actual cost of preparing each type of meal or snack must be determined, by completing a raw food cost survey and a meal preparation time study. The minimum period of time to be used for each of these must be the time it takes to complete a menu cycle. A menu cycle is defined as the period of time it takes to have the menu repeat, whether it is two weeks, a month, or some other period of time. If the menu or the menu cycle changes substantially (i.e., if child day care meals are different during the school year from the summer months), a new raw food cost survey and a new meal preparation time study are required to be completed.

Note that this example assumes that the noon meal for an individual receiving DAHS services and an individual receiving NF services is the same in content and portion size. If a particular meal requirement is not the same in content and/or portion size, as in the case of an individual receiving DAHS services and a child in day care, the meals must be tracked separately.

Section 2-Determining Food Costs by the Completion of a Raw Food Cost Survey

(A) For the menu cycle period of time, track and direct charge raw food costs to each type of meal and snack prepared for each type of program or business entity. This should be done on a daily basis. Total the costs for each type of meal or snack for the menu cycle period of time. In this example, the menu cycle is from April 1, 2009 through April 30, 2009.

	DAHS a.m. Snack	**NF Breakfast**	**DAHS/NF Noon Meal**	**DAHS/NF p.m. Snack**	**NF Evening Meal**	**NF Evening Snack**	**Total Kitchen**
Raw Food Costs *	$445.90	$1,549.10	$6,001.36	$351.20	$2,499.03	$303.91	$11,150.50

(B) The raw food cost, for the menu cycle period of time, for each type of meal and snack is then used to calculate a percentage. Calculate the percentages by determining the ratio of the raw food costs for each type of meal and snack to the total raw food costs for all meals and snacks.

Percentage of Total*	4.00%	13.89%	53.82%	3.15%	22.41%	2.73%	100.00%

(C) Allocate total raw food costs for the provider's cost-reporting period to each type of meal and snack by the raw food cost percentages calculated above in (B). In this example, the total raw food costs for the cost-reporting period as reflected on the provider's trial balance are $94,934.70.

Raw Food Costs for Reporting Period	$3,797.39	$13,186.43	$51,093.85	$2,990.44	$21,274.87	$2,591.72	$94,934.70

* These raw food costs should be supported by daily worksheet calculations which reflect the actual cost determined for each type of meal and/or snack. Raw food costs should be documented by food invoices and other supporting documentation.

Section 3-Determining Staff Costs by the Completion of a Meal Preparation Time Study

(A) For the menu cycle period of time, record the time spent by each staff person involved in the preparation of the meals and snacks by each type of meal and snack prepared. The timesheets should be kept in time increments of 30 minutes or less and should be kept on a daily basis during the menu cycle period of time. Total the time spent preparing each type of meal or snack for the menu cycle period of time. These totals should reflect the direct meal preparation time. Do not include in these totals the indirect time spent by staff (breaks, lunches, shopping, meetings, etc.); only include the direct meal preparation time. Total central kitchen staff salaries (direct and allocated) will be allocated based on the direct meal preparation time.

(B) For each staff person, use the time spent per meal and snack from (A) to calculate the percentage of the time spent on the preparation of each type of meal and snack. Calculate the percentages by determining the ratio of the time spent on each meal and snack to the total time spent on all meals and snacks.

(C) Multiply each staff person's total salary, payroll taxes, and benefits (PTB), as reflected in the provider's payroll records for the cost-reporting period, by the percentages calculated in (B) to each type of meal and snack.

	DAHS a.m. Snack	**NF Breakfast**	**DAHS/NF Noon Meal**	**DAHS/NF p.m. Snack**	**NF Evening Meal**	**NF Evening Snack**	**Total Kitchen**
Cook Hours**	20.50	19.25	40.00	10.75	39.25	10.50	140.25
Percentage of Hours	14.62%	13.73%	28.52%	766%	27.98%	7.49%	100.00%
Cook Salary, PTB for cost-reporting period	$2,584.82	$2,427.46	$5,042.34	$1,354.29	$4,946.86	$1,324.23	$17,680.00
Assistant Hours **	14.25	13.50	39.00	15.75	39.75	13.25	135.50
Percentage of Hours	10.52%	9.96%	28.78%	11.62%	29.34%	9.78%	100.00%
Assistant Salary, PTB for cost-reporting period	$1,126.90	$1,066.92	$3,082.91	$1,244.74	$3,142.90	$1,047.63	$10,712.00

Section 4 - Using Staff Hours to Determine Utilization

Total the hours collected during the menu cycle period of time for all staff by type of meal and snack. Calculate the percentage of the total time spent on the preparation of each type of meal and snack by determining the ratio of the time spent on each type of meal and snack to the total time spent on all meals and snacks during the period covered by the meal preparation time study.

	DAHS a.m. Snack	**NF Breakfast**	**DAHS/NF Noon Meal**	**DAHS/NF p.m. Snack**	**NF Evening Meal**	**NF Evening Snack**	**Total Kitchen**
Total Staff Hours	34.75	32.75	79.00	26.50	79.00	23.75	275.75
Percentage of Total Staff Hours	12.60%	11.88%	28.65%	9.61%	28.65%	8.61%	100.00%

** These amounts of time should be supported by daily timesheets which reflect the direct charge to each type of meal and/or snack.

Section 5 - Identifying Other Central Kitchen Costs

(A) For the provider's cost-reporting period, all central kitchen costs (other than food and staff costs) must be identified. These include, but are not limited to:

- Building costs, such as rent or depreciation, building insurance, utilities, maintenance, or mortgage interest. These building costs can be allocated to the central kitchen based on square footage.
- The cost/depreciation of kitchen equipment and appliances, such as refrigerators, stoves, etc.
- Costs of drivers and vehicles used to deliver the meals.
- Other related non-food costs such as kitchen supplies.

Central Kitchen Costs:	
Building rent	$5,993.20
Building insurance	$1,020.26
Utilities	$3,049.66
Pest Control	$151.44
Equipment	$55.30
Non-Food Supplies	$295.68
Total Other Central Kitchen (CK) Costs	$10,565.54

(B) The other central kitchen costs identified in (A) above will be allocated to each type of meal and snack based on staff utilization (i.e., based on staff hours).

Apply the percentages which were calculated Section 2 to the other central kitchen costs identified above to allocate them to each type of meal and snack.

	DAHS a.m. Snack	**NF Breakfast**	**DAHS/NF Noon Meal**	**DAHS/NF p.m. Snack**	**NF Evening Meal**	**NF Evening Snack**	**Total Kitchen**
Percentage of Total Hours	12.60%	11.88%	28.65%	9.61%	28.65%	8.61%	100.00%
Other Central Kitchen Costs	$1,331.25	$1,255.19	$3,027.03	$1,015.35	$3,027.03	$909.69	$10,565.54

Section 6 - Determining Cost Per Meal and Allocated Central Kitchen Costs

(A) Sum all costs of providing meals as calculated is Sections 2-5.

	DAHS a.m. Snack	**NF Breakfast**	**DAHS/NF Noon Meal**	**DAHS/NF p.m. Snack**	**NF Evening Meal**	**NF Evening Snack**	**Total Kitchen**
Raw Food Costs (Section 1)	$3,797.39	$13,186.43	$51,093.85	$2,990.44	$21,274.87	$2,591.72	$94,934.70
Cook Salary (Section 3)	$2,584.82	$2,427.46	$5,042.34	$1,354.29	$4,946.86	$1,324.23	$17,680.00
Assistant Salary (Section 3)	$1,126.90	$1,066.92	$3,082.91	$1,244.74	$3,142.90	$1,047.63	$10,712.00
Other Central Kitchen Costs (Section 5)	$1,331.25	$1,255.19	$3,027.03	$1,015.35	$3,027.03	$909.69	$10,565.54
Total Central Kitchen Costs	$8,840.36	$17,936.00	$62,246.13	$6,604.82	$32,391.66	$5,873.27	$133,892.24

(B) Divide the actual numbers of meals/snacks prepared during the cost-reporting period into the costs for each type of meal and snack as calculated in (A) above to determine an individual meal or snack cost.

Total Meals and Snacks***	$15,621	$7,851	$23,411	$22,001	$6,352	$6,498	$81,734
Cost per Meal/Snack	$0.5660	$2.2845	$2.6588	$0.3002	$5.0994	$0.9039	

(C) The actual number of meals/snacks prepared for each contract during the cost-reporting period is multiplied by the cost per meal or snack calculated in (B) above. Those costs are totaled by contract.

	DAHS a.m. Snack	**NF Breakfast**	**DAHS/NF Noon Meal**	**DAHS/NF p.m. Snack**	**NF Evening Meal**	**NF Evening Snack**	**Total Kitchen**
Actual Number of Meals and Snacks Provided:							
Adult Day Care (DAHS)	15,621		15,608	14,527			
NF		7,851	7,803	7,474	6,352	6,498	
Total Central Kitchen Costs:							
Adult Day Care (DAHS)	$8,841.49		$41,498.55	$4,361.01			$54,701.05
NF		$17,935.61	$20,746.62	$2,243.69	$32,391.39	$5,873.54	$79,190.85

DAHS Central Kitchen Costs to be reported on DAHS Accountability report $54,701.00

NF Central Kitchen Costs to be reported on NF Accountability report $79.191.00

*** The number of meals and snacks provided should be supported by daily worksheets.

(D) Develop the allocation percentages (to two decimals places) based on each program's total costs to the total of all programs total costs:

Shared Dietary Methodology Allocation Percentages:		Dietary Costs Percentage
Total DAHS	$54,701.00	40.85%
Total NF	$79,191.00	59.15%
Total all programs	$133,892.00	100.00%

(E) Apply the allocation percentages developed in (D) above to all the central kitchen costs to allocate to the appropriate line item:

		Allocated Shared Costs 40.85%	59.15%
Shared Dietary Expenses	Amount	DAHS	NF
Raw Food Costs	$94,934.70	38,780.82	56,153.88
Cook Salary	$17,680.00	7,222.28	10,457.72
Assistant Salary	$10,712.00	4,375.85	6,336.15
Building rent	$5,993.20	2,448.22	3,544.98
Building insurance	$1,020.26	416.78	603.48
Utilities	$3,049.66	1,245.79	1,803.87
Pest Control	$151.44	61.86	89.58
Equipment	$55.30	22.59	32.71
Non-Food Supplies	$295.68	120.79	174.89
Totals	$133,892.24	54,694.98	79,197.26

Appendix D. List of Useful Lives for Depreciation

STAIRS will assign useful lives based on data input in **Step 8.e**.. Provided below is an abbreviated list of some useful lives as stated in the American Hospital Association's 2008 guide (in alphabetical order from left to right). Refer to the AHA publication for items not listed. The 2008 guide is effective for depreciable assets placed in service during the 2008 and subsequent fiscal years. Depreciable assets place in service prior to the 2008 fiscal year should follow the guide in effect at the time or the 1993 guide.

Buildings ..... 30 yrs
Building Additions ..... 30 yrs
Cars and Minivans ..... 3 yrs
Light Trucks & Vans . 5 yrs
Buses and Airplanes . 7 yrs
Used Vehicles - see 1 TAC §355.103(b)(10)(C)(ii)

Asset	*Years*
Air Conditioning-5 tons or more	10
Apnea Monitor	7
Bed - Flotation Therapy	10
Bed - Manual	15
Bench - Metal or Wood	15
Breathing Unit - Positive Pressure	8
Camera - Video Tape	5
Chair - Geriatric	10
Chair - Shower/Bath	10
Computer - Laptop	3
Computer - Printer	5
Cooler - walk-in	15
Desk - Metal or Wood	20
Dresser	15
Emergency Generator	20
Fencing - Brick or Stone	25
Fencing - Wood	8
Flooring - Carpet	5
Flooring - Vinyl	10
Guard Rails	15
Intercom System	10
Lawn and Patio Furniture	5
Nurses' Counter - Built In	15
Oxygen Tank, Motor, and Truck	8
Paving - Asphalt	8
Photocopier - Large	5
Pump - Infusion	10
Refrigerator - Commercial	10
Shrubs and Lawns	5
Table - Food Prep	15
Table - Wood	15
Television	5
VCR	5
Wheelchair	5

Asset	*Years*
Air Conditioning System - Less than 5 tons	5
Bath - Whirlpool	10
Bed - Electric	12
Beepers - Paging	3
Bookcase - Metal or Wood	20
Cabinet	15
Cart	10
Chair - Guest	15
Chart Rack	20
Computer - Personal	3
Computer - Software	3
Curtains and Drapes	5
Dishwasher	10
Dryer - Clothes	10
Fax Machine	3
Fencing - Chain Link	15
Files - Regular	15
Flooring - Ceramic	20
Food Service Furniture	15
Housekeeping Furniture	15
Landscaping	10
Nurse Call System	10
Nursing Service Furniture	15
Parking Lot Striping	2
Paving – Concrete	15
Photocopier - Small	3
Railings - Handrails (interior)	15
Scale	10
Sofa	12
Table - Overbed	15
Telephone System	10
Ventilator/Respiratory	10
Washing Machine - Linen, Large	15
Work Station	10

Appendix E. Self-Insurance

Self-insurance means that the provider has chosen to assume the risk to protect itself against anticipated liabilities. Self-insurance can also be described as being uninsured. To qualify as an allowable self-insurance plan, a contracted provider must enter into an agreement with an unrelated party that does not provide for the shifting of risk to the unrelated party designed to provide only administrative services to liquidate those liabilities and manage risks. Such administrative costs are allowable costs that should be reported in **Step 8.f.**

There may be situations in which there is a fine line between self-insurance and purchased or commercial insurance. This is particularly true of "cost-plus" type arrangements. As long as there is at least some shifting of risk to the unrelated party, even if limited to situations such as provider bankruptcy or employee termination, the arrangement will not be considered self-insurance. Contributions to a special risk management fund or pool that is operated by a third party that assumes some of the risk and that has an annual actuarial review are allowable costs and are not considered self-insurance. Examples of such special risk management funds and pools include the Texas Council Risk Management Fund and the Texas Municipal League Intergovernmental Risk Pool.

- Allowable self-insurance costs for contracted providers include claims-paid (cash basis) costs, paid coinsurance provisions and deductibles and compensation paid to employees injured on the job where the contracted provider has received certificates of authority to self-insure from the Texas Workers' Compensation Commission.
- Contributions to the insurance fund or reserve that do not represent payments based on current liabilities and security deposits related to the Texas Workers Compensation Commission Certificate of Authority to Self-Insure are not allowable self-insurance costs.
- Self-insurance costs in excess of costs for similar, comparable coverage by purchased and/or commercial insurance premiums are subject to a cost ceiling. Documentation substantiating the cost of comparable coverage by purchased and/or commercial insurance premiums must be obtained and maintained as specified in 1 TAC §355.105(b)(2)(B)(ix) of this title. Refer to 1 TAC §355.103(b)(13)(E).

Cost Ceilings

For employee-related self-insurance (health, dental, worker's comp, etc.), the ceilings are either

- Cost that would have been incurred if purchased through a commercial policy or
- Cost equal to 10% of payroll of employees eligible for coverage

For non-employee related self-insurance (vehicle, building, etc.), the ceiling is the cost that would have been incurred if purchased through a commercial policy.

The amount above the ceiling may be calculated and carried over to future periods in the following manner.

For the initial reporting period:

1. Sum the allowable purchased insurance costs and the paid self-insurance claims for the cost-reporting period.
2. Calculate the self-insurance cost ceiling for the reporting period.
3. Compare items 1 and 2. If item 1 exceeds item 2, the costs in excess of the ceiling may be carried forward and expensed in future cost-reporting periods.

For subsequent reporting periods:

1. Sum the allowable purchased insurance costs and the paid self-insurance claims for the cost-reporting period.
2. Calculate the self-insurance cost ceiling for the reporting period.
3. Compare items 1 and 2.
    a. If item 1 exceeds item 2, the costs in excess of the ceiling may be carried forward and expensed in future cost-reporting periods.
    b. If item 1 is less than item 2, add excess carry-forward amounts from previous reporting periods until the calculated cost ceiling is met.

Documentation Requirements

Maintain documentation that supports the amount of claims paid each year and any allowable costs to be carried forward to future cost-reporting periods.

For employee-related self-insurance, obtain each fiscal year's documentation to establish what premium costs would have been, had commercial insurance for total coverage been purchased **OR** determine the ceiling based on 10% of the payroll for the employees eligible for receipt of the particular coverage/benefit.

For non-employee related self-insurance, document the cost that would have been incurred if item were fully insured. Documentation must include bids from two commercial carriers and documented bids must be obtained at least once every three years.

Appendix G - Schedules D, E, and G

Schedule D1: Nursing Facility Building Lease Information

If you lease your nursing facility building, you must complete Schedule D1 and attach a copy of the lease agreement(s) in effect during your cost-reporting period. A copy of the lease agreement must be attached to **each** year's accountability report and properly cross-referenced: submission of the lease agreement with a prior year's accountability report does not exempt a facility from the requirement to submit a copy of the agreement with the current accountability report Schedules and attachments. The lease agreement must be signed by all interested parties and include all sections and attachments.

If the name of the leased facility as listed on the lease is different from the name of the facility as listed on the cover page of the automated accountability report, please provide a written explanation for the difference.

Item 1 (Type of Ownership of Lessor Entity): If the type of ownership of your lessor entity is not listed in item 1 (e.g., a trust), please indicate the type of ownership by writing it in.

Item 2 (Lessor Entity Identification): Complete all lines. Note that this year, we have added space for the name, title, and phone and fax number of a contact person with the lessor entity.

Item 3 (Related Party Information): If you check "Yes" on this item, you must complete Schedule B, Sections 1A and 3.

Item 4 (Lessor Entity Owners): Please note that this year, in addition to name and title, are required to provide the percent ownership for each individual with 5% or more ownership interest in the lessor entity. If the lessor ownership type is a trust, list each beneficiary of the trust with 5% or more interest in the trust.

Note: If indicated "Yes" on Step 8a (Was the nursing facility building leased during the cost-reporting period?) and/or reported a cost on Step 8f (Rent / Lease - Building and Building Equipment Program Admin & Operations), you must complete Schedule D.

If two or more leases were in effect during your cost-reporting period, you must complete a separate Schedule D for each lease and provide a table showing the time period each lease was in effect.

Schedule D2: Central Office/Shared Administration Building Lease Information

See instructions above for Schedule D1. It is not required to submit with the accountability report Schedules and attachments a copy of the central office/shared administration building lease unless the lease is with a related party individual/organization. Central office leased building costs should be reported in Step 8f Rent / Lease - Building and Building Equipment Central Office.

Schedule E: Contract Management Information

If the facility received contracted facility management services (as defined in the Definitions section of these instructions), Schedule E must be completed and a copy of the management agreement(s) in effect during your cost-reporting period must be uploaded to STAIRS. A copy of the management agreement must be uploaded with each year's accountability report and properly cross-referenced: submission of the agreement with a prior year's accountability report does not exempt a facility from the requirement to submit a copy of the management agreement with the current accountability report Schedules and attachments. The management agreement must be signed by all interested parties and include all sections and attachments. If there is no written management agreement, attach and cross-reference a written explanation as to why this is so.

Item 1 (Type of Ownership of Managing Entity): If the type of ownership of your managing entity is not a listed option in item 1 (e.g., a trust), please indicate the type of ownership by writing it in.

Item 2 (Managing Entity Identification): Complete all lines. Note that this year, we have added space for the name, title, and phone and fax number of a contact person with the managing entity.

Item 3 (Related Party Information): Indicate Yes or No.

Item 4 (Managing Entity Owners): Please note that this year, in addition to name and title, are required to provide the percent ownership for each individual with 5% or more ownership interest in the managing entity. If the managing entity ownership type is a trust, list each beneficiary of the trust with 5% or more interest in the trust.

Note: If the provider answered "Yes" to "Do you have any contracted management costs to report?" on Step 6a and/or reported a cost for "Fees - Management Contract" on Step 8f, the provider must complete Schedule E. The provider must complete Schedule E for both nonrelated party and related party management agreements. Related party management expenses must be reported at the cost to the related party as central office expenses, with the costs separately reported by cost category as applicable in Step 7 (Payroll Taxes) and Step 8f. Central Office costs may not be collapsed into a single item.

If two or more management agreements were in effect during your cost-reporting period, you must complete a separate Schedule E for each management agreement and provide a table showing the time period each agreement was in effect.

Schedule G: Ancillary Costs for Medicaid-Only Residents

Notes:

The advent of the Medicare Prospective Payment System (PPS) for skilled nursing facilities should have no impact on how to complete Schedule G. The Medicare Condition of Participation requiring nursing facilities to accrue charges for all residents (Medicare and non-Medicare) who receive ancillary services remains in effect. According to this requirement, ancillary charges must be based on a uniform charge structure and recorded at the same rate, for the same service, for all residents. Consequently, you should be able to properly complete Schedule G for your 2020 Texas Nursing Facility Cost Report in the same manner as instructed in previous years.

For Medicaid cost-reporting purposes, only ancillary costs incurred for providing ancillary services to Medicaid-Only residents that are not reimbursable through the HHSC Specialized Services or Rehabilitative Services programs may be included on this cost report. Costs incurred, and revenues accrued for providing ancillary services to Non-Medicaid residents are unallowable and must not be included on this cost report. Ancillary services refer to services that are not routine. A charge separate from the routine "daily charge" for non-Medicaid residents is customarily or, historically, has been, made for ancillary services.

Schedule G is not intended to capture building or departmental equipment expenses. Ancillary building and departmental equipment expenses associated with entities other than the nursing facility should be removed from the accountability report through the use of appropriate allocation methods. Ancillary building and departmental equipment expenses associated with the nursing facility should be reported on the appropriate automated accountability report items.

Therapy services provided by staff of a nursing facility only to residents of that nursing facility (and not provided to persons outside the facility) are not considered a separate business component but are considered non-routine nursing facility services. Therefore, shared facility-level costs that support the entire facility including therapy services, such as the administrator, facility office staff, and facility building and operational costs, and the related central-office costs, do not need to be allocated and removed from the cost report. Other direct therapy-related expenses should be reported according to the instructions for Schedule G.

Therapy services provided from the central office, a separate division/unit of a company, or a related company separate from the nursing facility (which may or may not serve persons outside the facility), are considered a separate business component and those costs that cannot be directly charged to the nursing facility must be allocated based upon the total-cost-less-facility-cost method, the labor method, applicable time studies, or acceptable functional methods. Units of service is not an acceptable allocation method in this situation.

Medicaid-Only Residents

" **Medicaid-Only** residents" refers to residents who are eligible recipients of Medicaid Nursing Facility Vendor Payments and who ***ARE NOT ELIGIBLE*** for payments for Ancillary Services from other sources such as Medicare or Private Insurance.

Non-Medicaid Residents

"**Non-Medicaid** residents" refers to all residents other than Medicaid-only residents as defined above and includes, but is not limited to, Private, Private Insurance, Veterans Administration, Qualified Medicare Beneficiary (QMB), Medicaid Qualified Medicare Beneficiary (MQMB) and Dual Eligible (Medicare/Medicaid) residents.

Section 1 (Ancillary Costs for Medicaid-Only Residents) - Completion Instructions

Providers Who Do Not Participate In The Medicare Program

Providers who do not participate in the Medicare program are to complete Columns F and G only (leaving Columns B through E blank). Schedule G was designed based on Medicare Conditions of Participation that specify certain accounting/bookkeeping requirements; therefore, providers who do not participate in the Medicare program are unable to use Columns B through E to calculate their Medicaid ancillary costs. Non-Medicare providers must use reasonable methods to identify and calculate their costs incurred for providing ancillary services to Medicaid-Only residents.

Providers Who Participate In The Medicare Program

Providers who participate in the Medicare program will fall under one of two categories: (1) those whose accounting records separately identify the costs incurred to provide ancillary services to Medicaid-Only and Non-Medicaid residents and (2) those whose accounting records do not.

Medicare Providers Who Maintain Separate Records

Medicare providers who maintain accounting records that separately identify the costs incurred to provide ancillary services to Medicaid-Only and Non-Medicaid residents are to complete Columns F and G only (leaving Columns B through E blank) for each type of ancillary item that applies. See instructions for Columns F and G.

Medicare Providers Who DO NOT Maintain Separate Records

Medicare providers who do not maintain accounting records that separately identify the costs incurred to provide ancillary services to Medicaid-Only and Non-Medicaid residents are to complete Columns B through G in order to calculate the portion of their ancillary costs attributable to Medicaid residents. Schedule G is designed based on the Medicare Condition of Participation that requires nursing facilities that participate in the Medicare program to accrue charges for all residents (Medicare and non-Medicare) who receive ancillary services. According to these requirements, ancillary charges must be based on a uniform charge structure and recorded at the same rate, for the same service, for all residents. Therefore, the costs of the ancillary services provided to different types of residents are proportionally related to the recorded revenues for those residents. Because of this Medicare requirement, the cost of Medicaid ancillary services can be calculated using the recorded Medicaid ancillary revenues.

Column A (Ancillary Description) - Identify the type of ancillary service.

Column B (Gross Ancillary Revenue For All Residents) - Enter the total amount of ancillary revenues accrued for ancillary services provided to all residents, both Medicaid-Only and non-Medicaid.

Column C (Gross Ancillary Revenue For Medicaid Residents Only) - Enter the amount of ancillary revenue accrued for ancillary services provided to *MEDICAID-ONLY RESIDENTS.*

Column D (Percent of Medicaid-Only Ancillary Revenue) - Calculate the percentage of Medicaid-Only ancillary revenue to total ancillary revenue by dividing the amount in Column C by the amount in Column B. Record this percentage in Column D (with a minimum of 2 decimal places).

Column E (Ancillary Cost For All Residents) - Enter the total amount of ancillary cost for all residents, both Medicaid-Only and Non-Medicaid. **Subtract** from this amount any reimbursements received from the HHSC Specialized Services or Rehabilitative Services programs. Report net expenses, meaning gross expenses less any discounts, rebates, or allowances.

Column F (Medicaid-Only Ancillary Cost) - If completing Columns B through E, calculate the amount of allowable Medicaid ancillary cost by multiplying the total ancillary cost in Column E by the Medicaid ancillary revenue percentage in Column D.

If completing Columns F and G only, enter in Column F the cost incurred for providing each applicable type of ancillary service to **Medicaid-Only Residents. Subtract** from this amount any reimbursements received from the HHSC Specialized Services or Rehabilitative Services programs. Report net expenses, meaning gross expenses less any discounts, rebates, or allowances.

Column G (Breakdown of Column F) - Column G identifies the cost report item number(s) on which all Medicaid ancillary costs must be reported (item numbers other than those provided are not to be used for reporting these costs). Enter the cost from Column F under the item number(s) provided in Column G that most properly identifies the Medicaid ancillary cost incurred. If it is necessary to allocate costs between item numbers, attach (and properly cross-reference) documentation that identifies the method of allocation used and details how the allocation was made. In addition, indicate the type of allocation method(s) used in Step 6.d.

For each ancillary type, ensure that the sum of the amount(s) reported in Column G is equal to the corresponding Medicaid ancillary cost in Column F. For example, if your facility's direct ancillary cost for Medicaid-Only residents for physical therapy was $10,000 with $8,000 accrued for Ancillary Therapists' salaries and wages and $2,000 accrued for Therapy Supplies, then $10,000 would be entered in Column F, $8,000 under Step 6d Box 1 in Column G and $2,000 under Step 8f Box 3 in Column G.

Row 1 thru 4 Notes: Ancillary Therapist, Contracted, Assistant, and Contracted Assistant Therapy costs include (1) salaries and wages for (a) Physical Therapists or Physical Therapy Assistants licensed by the Texas State Board of Physical Therapy Examiners (b) Occupational Therapists or Occupational Therapy Assistants licensed by the Texas State Board of Occupational Therapy Examiners, (c) Speech Therapists (Pathologists) licensed by the Texas State Board of Examiners of Speech-Language Pathology and Audiology, (d) Respiratory Therapists (inhalation therapist) licensed by the Department of State Health Services Respiratory Care Practitioners Program, (e) Intravenous Therapy (the injection of fluids directly into veins), and (f) Air Fluidized Therapy (costs associated with are-fluidized therapy beds.

Row 5 Notes: Other Ancillary Therapy costs include therapy costs other than those indicated above.

Row 6 Notes: Contract Other Ancillary Staff costs include those types provided in Row 5 above but by Contracted personnel.

Row 7 Notes: Costs for Therapy Supplies should be reported here.

Row 8 Notes: Physical Therapy costs include (1) salaries and wages for physical therapists licensed as physical therapists by the Texas State Board of Physical Therapy Examiners and physical therapy assistants licensed as physical therapy assistants by the Texas State Board of Physical Therapy Examiners and (2) the cost of physical therapy supplies, physical therapy consultants and contract and off-site physical therapy.

Occupational Therapy costs include (1) salaries and wages for occupational therapists licensed by the Texas Board of Occupational Therapy Examiners and occupational therapy assistants licensed by the Texas State Board of Occupational Therapy Examiners and (2) the cost of occupational therapy supplies, occupational therapy consultants and contract and off-site occupational therapy.

Speech Therapy costs include (1) salaries and wages for speech-language pathologists who are Texas licensed speech-language pathologists or who meet the educational requirements for license and have accumulated, or are in the process of accumulating, the supervised professional experience (the internship) required for license and audiologists who are Texas licensed audiologists or who meet the educational requirements for license and have accumulated, or are in the process of accumulating, the supervised professional experience (the internship required for license) and (2) the cost of speech therapy supplies, speech therapy consultants and contract and off-site speech therapy.

Row 9 Notes: Report the costs for Contracted and Off-Site Therapy (those not included in Rows 2, 4, or 6) on this row.

Row 10 Notes: Supplies: Nutritional Therapy Supplies, Medical, Nursing & Incontinent Nutritional Therapy (Excluding Food Supplies) includes supplies and specialized staff costs related to the delivery of parenteral and enteral nutrition. Do not include the cost of the actual parenteral or enteral nutrition in this row; those costs should be reported in Row 16. The delivery of Ensure and other similar products enterally (e.g., through a feeding tube) is not considered an ancillary service and the cost of supplies related to the delivery of such products should be reported in **Step 8.f.** (Supplies: Nursing and Medical)***.***

Nutritional Therapy Food Supplies includes the costs of parenteral and enteral nutritional products. Do not include the costs of and specialized staff related to the delivery of these products to the resident; those costs should be reported in Row 10. Ensure and similar products are not considered ancillary products and the costs of Ensure, etc., should be reported as food costs in Step 8f Contract Dietary Services.

Chargeable Medical and Nursing Supplies include such items as surgical dressings, and splints, casts and other devices used for the reduction of fractures and dislocations, prosthetic devices (other than dental and devices related to incontinence) which replace all or part of an internal body organ, leg, arm, back and neck braces, trusses, and artificial legs, arms and eyes. Medical and nursing supplies (such as tongue depressors, swabs, Band-Aids, cotton balls, alcohol, and incontinent supplies) which are routinely provided to Medicaid and non-Medicaid residents and are not chargeable (or considered) as ancillaries to Medicare or other non-Medicaid sources are not to be included in this section. Because these supplies are considered routine items, treat these supply costs as routine by adding them to the medical and nursing supplies costs in **Step 8.f**. The associated charges, if any, made to non-Medicaid residents would be added to the routine daily revenues reported on page 5 in the appropriate resident category.

Chargeable Incontinent Supplies include urinary collection and retention systems including Foley catheters when ordered for a resident with permanent urinary incontinence as well as colostomy bags and necessary accoutrements required for attachment and other supplies directly related to ostomy care. Do not include chucks, diapers, rubber sheets, etc. Urinary collection and retention systems that are not for

residents with permanent urinary incontinence should be reported as "Supplies - Nursing and Medical" in **Step 8.f**.

Note: Due to a problem in STAIRS, you may not be able to enter the Nursing Supplies in **Step 8.f.** as Related Party. If this is the case, enter the cost as Non-Related Party and include a note in the Notes box that it is actually Related Party.

Row 12 Notes: Diagnostic Laboratory and Radiology
Diagnostic X-ray tests provided by the NF if the NF has a radiological department that meets the same standards required of a hospital under Medicare or if the NF meets the portable X-ray supplier standards under Medicare are to be reported on Schedule G, Row 8. Laboratory services if the NF has a valid Clinical Laboratory Improvement Act (CLIA) certificate that covers the types of testing performed by the NF are to be reported on Schedule G, Row 8. X-ray, Radium and Radioactive Isotope Therapy provided by the NF if the NF has a radiological department that meets the same standards required of a hospital under Medicare are to be reported on Schedule G, Row 8. Personnel costs related to these items are to be transferred from Column G to Step 6d Box 1 while other related costs are to be transferred from Column G to **Step 8.f.** Box 9.

Row 13 Notes: Drugs and Pharmaceuticals
Chargeable Drugs and Pharmaceuticals include drugs included or approved for inclusion in the U.S. Pharmacopoeia, the National Formulary, or the U.S. Homeopathic Pharmacopoeia or, except for those unfavorably evaluated, in AMA Drug Evaluations. Also included are hemophilia clotting factors and other blood products. None of these items should have been paid for through the Medicaid vendor drug program or any other payment source if they are reported as Medicaid-only costs on Schedule G.

Row 14 Notes: Oxygen
Chargeable Oxygen includes oxygen therapy where the need and effectiveness is documented, where there is a physician's order stating the oxygen device and/or the specific flow rate or concentration of oxygen required and where periodic assessment of arterial PO2 or oxygen saturation is performed. Oxygen delivered "PRN" or "as needed" does not meet these requirements and should be reported as " Resident Care: Supplies Program Admin & Operations" in **Step 8.f**. An intermittent or PRN oxygen therapy order must include time limits and specific indications for initiating and terminating therapy. Non-depreciable equipment associated with the delivery of oxygen must be reported under routine medical supplies in **Step 8.f**. Effective for purchases made on or after the beginning date of the provider’s 2004 fiscal year, non-depreciable equipment is equipment that cost less than $5,000 or has a useful life of less than one year, whereas depreciable equipment is equipment that cost $5,000 or more and has a useful life of more than one year. As well, purchases made before the provider’s 2004 fiscal year that cost more than $1,000 and have a useful life of more than one year must be depreciated using the straight-line method. For all contracted providers: for purchases made after the beginning of the contracted provider’s fiscal year 2019, an asset valued at $5,000 or more and with an estimated useful life of more than one year at the time of purchase must be depreciated or amortized, using the straight-line method. In determining whether to expense or depreciate a purchased item, a contracted provider

may expense any single item costing less than the capitalization level for that fiscal period as described above or having a useful life of one year or less. If the equipment meets the definition of DME, the depreciation costs should be reported in **Step 8.f**.

Row 15 Notes: DME Purchased by Provider
Chargeable DME and Equipment Rental includes medical equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury and is appropriate for use in the resident's place of residence (i.e., the NF). Do not include depreciable DME. Depreciable DME should be reported on **Step 8.f**. General use wheelchairs and hospital beds not prescribed by a physician are not considered DME and should not be depreciated as departmental equipment (**Step 8.f.**)

Row 16 Notes: DME Rental/Lease Expense
Chargeable DME and Equipment Rental includes medical equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury and is appropriate for use in the resident's place of residence (i.e., the NF). Do not include depreciable DME. Depreciable DME should be reported on **Step 8.f**. General use wheelchairs and hospital beds not prescribed by a physician are not considered DME and should not be depreciated as departmental equipment (**Step 8.f.**)

Section 2 (Ancillary Direct-Care Staff Paid Hours for Medicaid-Only Residents) - Completion Instructions

For Medicaid cost-reporting purposes, only ancillary direct-care staff paid hours spent providing ancillary services to **Medicaid-Only** residents may be included on this automated cost report

Using Section 2 of Schedule G, for each staff type (i.e., Ancillary Therapists, Ancillary Therapy Assistants, and Other Ancillary Staff) for each type of therapy (e.g., Physical Therapy, Occupational Therapy, Speech Therapy, etc.,) perform the following steps:

1. Determine the total paid hours by staff type and therapy type and enter the value in the applicable Column A;
2. Determine the percent Medicaid-only revenue applicable to the type of therapy from Schedule G, Section 1, Column D and enter the value in the applicable Column B.
3. Multiply the value in Column A by the value in Column B and enter the product in Column C.
4. In Row 7, for each staff type, sum the values in Column C. The sum values in Row 7,
5. Column C are the Medicaid-only paid hours to be reported on the cost report for each staff type (i.e., Step 6d for Ancillary Therapists' hours, **Step 6.d.** for Ancillary Therapy Assistants' hours, and Step 6d for Other Ancillary Staff hours).

Section 3 (Ancillary Indirect Costs for Medicaid-Only Residents) - Completion Instructions

Ancillary indirect expenses are central office expenses (i.e., shared administrative expenses) related to the provision of ancillary services. For Medicaid cost-reporting purposes, only appropriately allocated ancillary indirect expenses related to the provision of ancillary services for Medicaid-Only residents may be included on this cost report. Ancillary administrative costs at the facility level are not to be reported on Schedule G; rather they should be reported in the appropriate items in the Administration Costs section of the cost report.

For each type of Ancillary Indirect cost (i.e., salaries and wages, payroll taxes and workers' compensation, employee benefits and contracted supervision), enter the ancillary indirect expense in column B, the total direct ancillary cost for all residents (from Schedule G, Section 1, Row 17, Column E) in Column C and the total direct ancillary cost for Medicaid-only residents (from Schedule G, Section 1, Row 17, Column F) in Column D. Divide the value in Column D by the value in Column C and multiply the result by the value in Column B, enter the product in Column E. The values in Column E are the Indirect Ancillary Costs for Medicaid-only residents to be reported in **Step 7**. and **Step 8.f**.

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 accountability report. If the provider's accountability 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 accountability report preparer should submit a revised accountability 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.

Allocation - A method of distributing costs on a pro rate basis. For more information, see Cost Allocation Methods in the General Instructions section and the 2019 or 2020 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. *1 TAC §355.103(b)(7)*

Ancillary Revenues - a separate charge from the routine "daily charge" for room/board that is customarily made or has historically been made for ancillary services. See also definition of *Ancillary Services*.

Ancillary Services - certain services provided to residents in addition to routine nursing facility services (e.g., therapies, radiology, and laboratory). See also *Specific Instructions* for Schedule G and definition of *Routine Services*.

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.

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

Certified Nursed Aide – A staff person (employee or contracted) who has completed at least the first 16 hours of classroom nurse aide certification training, since the completion of the first 16 hours of classroom nurse aide certification training allows the staff person to provide direct care services to the residents under nurse supervision. Any time worked before completion of the first 16 hours of classroom nursing aide certification training (i.e., time worked as a hospitality aide) cannot be reported as a nurse aide but must be reported in item 160 as "Other Resident Care Staff – Nonprofessional".

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

1 TAC §355.102(i)(1)

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 – Licensed beds contracted with Medicaid to provide services to Medicaid residents. These beds can be occupied by Medicaid residents and other residents (e.g., private pay, private insurance, VA). See Instructions for **Step 5**.

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 accountability report. See Instructions for **Step 4.**

Contractual Adjustment – (Primarily Medicare) difference between the gross revenue recorded and the amount of reimbursement received which is not paid by any payer source. The amount of revenue reported on the accountability report should be net of all contractual adjustments. Contractual adjustments are not to be reported as Bad Debt and Charity or Courtesy Allowance.

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.

Custodial Care - See the definition for personal care.

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 - resident care provided by nursing personnel (i.e., RNs, LVNs, Medication Aides, Restorative Aides, Certified Nurse Aides), in order to carry out the physician's planned regimen of total resident care. To be allowable as direct care staff, an individual must both meet the appropriate professional certification or licensure requirements and perform nursing-related duties. The actual time (i.e., directly charged time) spent working in one of these positions for the nursing facility must be reported.

Nursing personnel who work performing both nursing facility direct care functions and other functions (e.g., nursing facility administrative functions or any functions for other business components such as a retirement center, residential care center, assisted living component, etc.) must maintain daily, continuous timesheets. The daily timesheet must document, for each day, the person's start time, stop time, total hours worked, and the actual time worked (in increments no greater than 30 minutes) performing nursing facility direct care functions and the actual time worked performing other functions. Time must be directly charged and allocation of time is not acceptable in such situations.

The only exception to the "no allocation rule" is when nursing personnel work for both Medicaid-contracted and noncontracted licensed nursing facility beds. In such a situation, if the hours and costs cannot be reasonably direct costed in accordance with the Centers for Medicare and Medicaid Services (CMS) requirements for distinct reporting, the hours worked and associated costs must be allocated between contracted and noncontracted beds based upon units of service (i.e., resident days) and an acceptable allocation summary must be attached.

Staff members who perform more than one function in a facility <u>without a differential in pay between functions</u> are categorized at the highest level of licensure or certification they possess. If this highest level of licensure or certification is not that of an RN, LVN, medication aide, restorative aide or certified nurse aide, the staff member is not to be included in the direct care staff cost center. The only exceptions to this rule are respiratory therapists in facilities receiving the ventilator and/or pediatric tracheotomy supplemental payments (see "Common Questions/Issues #9). Administrators and assistant administrators are not direct care staff and should not be included in the direct care staff items.

Paid feeding assistants are <u>not</u> included in the direct care staff cost center and are not to be counted toward staffing requirements. Paid feeding assistants are intended to supplement certified nurse aides, not to be a substitute for certified or licensed nursing staff. Report paid feeding assistants in **Step 6.d.**.

Required documentation of direct care staff hours and compensation includes, but is not limited to, proof of licensure and certification status, time sheets (for staff performing more than one function or working for more than one entity), job descriptions and payroll records.

1 TAC §355.308(a)

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*.

Dually Certified Beds - Beds contracted to provide nursing facility services to Medicaid residents that are also certified for participation in the Medicare program. These are considered contracted beds.

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 accountability 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 in the course of the practitioner's practice.

Manager - A person, other than a licensed nursing home administrator, having a contractual relationship to provide management services to a contracted nursing facility provider. If the contracted manager and the provider are related by common ownership or control, the related party management costs must be reported as central office costs **Step 6.e.**.

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 accountability 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, Veterans Administration, Qualified Medicare Beneficiary (QMB), Medicaid Qualified Medicare Beneficiary (MQMB) and Dual Eligible (Medicare/Medicaid) residents/participants.

Non-Participating Beds - Licensed nursing beds that are not contracted with Medicaid or Medicare.

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)

Personal Care - (sometimes referred to as "custodial care" or "assisted living") services primarily for the purpose of helping with the activities of daily living (such as eating, dressing, grooming, bathing, toileting, transferring, ambulating, mobility or assistance with or self-administration of medications). Personal care services do not include nursing services.

Personal Care Beds – Beds not licensed by the Health and Human Services Commission (HHSC) as nursing beds or beds licensed by HHSC as personal care beds (and not as nursing beds). Personal care beds are not noncontracted nursing beds; no statistics, revenues, or costs related to personal care beds should be reported on a nursing facility accountability report.

Provider - The individual or legal business entity that is contractually responsible for providing Medicaid services, i.e., the business component with which Medicaid contracts for the provision of the services to be reported in this accountability report. Also known as contracted provider. See definitions for *Component Code, Contracting Entity*, and *Accountability 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 accountability 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 NF - Rules by which HHSC determines daily payment rates for nursing facility services that are statewide and uniform by class of service.

1 TAC §355.306-308 and §355.403

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 substeps 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 accountability 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.

Routine Services – Sometimes referred to as the "room-and-board" charge for nursing facility services. Included in routine services are regular room, dietary and nursing services, minor medical and nursing supplies and certain equipment and facilities. Ancillary services are **not** routine services (see definition of *Ancillary Services*). Refer to 40 TAC §19.2601, Vendor Payment (Items and Services Included) for a complete listing of routine services.

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.

1 TAC §355.103(b)(13)(B)

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 payments may be withheld from contracted providers in certain specific situations, as described in 1 TAC §355.403, §355.308, and §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.*