2022 Cost Report and 2023 Accountability Report Instructions for Nursing Facility (NF)

For assistance with:

Report completion
PFD (PFD) Long Term Services and Supports (LTSS) Center for Information and Training
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:
https://cr.fairbanksllc.com/fairbanksllc/pages/login.jsf

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

February 2022
Texas Health and Human Services Commission

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Purpose of a Cost Report

The purpose of a Medicaid Cost Report is to gather financial and statistical information for Health and Human Services Commission (HHSC) Provider Finance Department (PFD) to use in developing reimbursement rates. Some cost reports are also used in the determination of accountability under the Direct Care Staff Compensation Rate Enhancement program.

Reporting Period

The reporting period is generally the period of time during the contracted provider's 2022 fiscal year during which its contract was in effect. 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 email costinformationpfd@hhs.texas.gov before continuing with cost report preparation. Refer to the *Instructions,* **Step 2** for additional assistance.

Cost Report Requirements

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

- attend and receive credit for the 2022 Cost Report training/webinar session sponsored by HHSC. Preparers without the proper credit will not be able to access the STAIRS data entry application;
- Read these instructions carefully;
- Create a comprehensive reconciliation worksheet to serve as a crosswalk between the facility/contracted provider’s accounting records and the cost report;
- Create worksheets to explain adjustments to year-end balances due to the application of Medicaid cost reporting rules and instructions; and
- Review the provider’s most recently audited cost report and audit adjustment information. If adjustment information has not been received, call (737) 867-7812.

Cost Report Resources

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

Who Must Complete this Report?

For 2022, Nursing Facility providers are required to submit financial and statistical information through a cost report for each contract held with the State of Texas, a STAR+PLUS contract held with a Managed Care Organization, or both.

It is the responsibility of each contracted provider to submit an accurate cost report completed following all applicable instructions and rules.

NF providers must complete and submit a 2022 NF Cost report. The only exception to this requirement is if the provider did not provide billable direct care staff services to HHSC recipients during the reporting period.

Excusals

A provider may be excused from the requirement to submit a cost report based on meeting one or more of the following conditions:

- If the provider performed no billable services during the provider's cost-reporting period.
- If the cost-reporting period would be less than or equal to 30 calendar days or one entire calendar month and not in the Rate Enhancement Program.
- If circumstances beyond the provider's control, such as the loss of records due to natural disasters or removal of records from the provider's custody by a regulatory agency, make cost-report completion impossible.
- If all of the contracts the provider is required to include in the cost report have been terminated before the cost-report due date.
- If the total number of days that the provider performed service for HHSC recipients during the cost-reporting period is less than the total number of calendar days included in the cost-reporting period times 1.5.

Contact HHSC PFD at costinformationpfd@hhs.texas.gov to determine if you qualify for an excusal.

Required Cost Report Training

To be able to submit a 2022 cost report, a preparer must attend the 2023 Cost Report Training/webinar. Preparers without the proper training credit will not be able to access the STAIRS data entry application.

All HHSC sponsored cost report training will be offered via webinar. Each webinar will include how to enter a report into the State of Texas Automated Information Reporting System (STAIRS).

Upon completion of the appropriate webinar, preparers will be given the appropriate credit to be qualified to submit a cost or accountability report. A cost report preparer list will be published on the HHSC PFD LTSS webpage and will be updated as applicable. Attendees of a Cost Report Training/webinar will not receive a certificate as HHSC PFD 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.

State of Texas Automated Information System (STAIRS)

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

Access to STAIRS

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 should 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.

COVID-19 Funding

The HHSC PFD developed the below information to provide guidance and address questions pertaining to the Cost/Accountability Reports related to COVID-19. The following sections include guidance on COVID-19-related revenue providers may have received and instructs providers on when to report or offset revenue against incurred expenses.

CARES ACT and TAC Rule Guidance

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" 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 2020 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 healthcare providers, services, and support providers 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 2022 Cost/Accountability Reports, providers and cost report preparers should offset any PRF recognized as revenue by the provider in 2022 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 in 2022 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 in 2022 as a result of lost revenue should instead be reported as "Gifts, Grants, Donations, Endowments and Trusts" on step 5.c. of the 2022 cost 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.

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 of $10,000 and met the requirements for forgiveness prior to its 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

Nursing Facility (NF) 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).

NF providers may utilize the additional funding for COVID-related expenses, including direct care staff salary and wages, PPE, and dietary needs and 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 Direct Care Staff Compensation Rate Enhancement program receive additional funds to provide increased wages and benefits for direct care staff and must demonstrate compliance with enhanced staffing and spending requirements. Spending requirements related to rate enhancement are only applicable to paid units reported on the cost/accountability reports. TAC Section 355.308(j) 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 section 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 documentation (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.

Applicable TAC Rules and Informational Resources

The following rules and instructions govern this cost report.

- Cost Determination Process Rules at Title 1 of the Texas Administrative Code (TAC) Sections 355.101-355.110;
- Nursing Facility (NF) program-specific rules at 1 TAC Sections 355.306-355.308 and 355.403;
- The *Instructions* for completion of the report;
- The 2022 general and program-specific Cost Report training materials.

As stated at 1 TAC Section 355.105(b)(1), federal tax laws and Internal Revenue Service (IRS) regulations do not necessarily apply in the preparation of Texas Medicaid Cost Reports. Except as specified in HHSC's Cost Determination Process Rules, cost reports should be prepared consistently 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.

Due Date and Submission

The cost report is due to HHSC PFD on or before **April 30, 2023.**

All attachments and digitally signed and/or 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)

Failure to File an Acceptable Cost Report

Failure to file a cost report completed in accordance with instructions and rules by the cost 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 1 TAC Section 355.111. Also refer to 1 TAC Section 355.105(b)(4)(C)(ii)

Extensions Granted Only for Good Cause

Extensions of cost report due dates are limited to those requested for good cause. Good cause refers to extreme circumstances beyond the contracted provider's control and for which adequate advance 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 cost report. The provider (owner or authorized signor) must make the extension request. The extension request must clearly explain the necessity for the extension and specify the due extension date being requested. Failure to file an acceptable cost report by the original cost 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 1 TAC Section 355.111. Also refer to 1 TAC Section 355.105(c)(3)

Standards for an Acceptable Cost Report

To be acceptable, a cost report must:

1. Be completed in accordance with the Cost Determination Process Rules, program-specific rules, cost report instructions, and policy clarifications;
2. Be completed for the correct cost-reporting period (Note that the cost-reporting period has been prepopulated. See **Step 4.** If a 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 Cost 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 (Cost 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. If allocated costs are reported, including acceptable allocation summaries, uploaded into STAIRS.
9. Have uploaded in STAIRS a detailed asset listing/depreciation schedule if the summary method of reporting was used in **Step 8.e**.
10. Have uploaded in STAIRS a worksheet supporting related party building rent/lease if the summary method of reporting was used in **Step 8.e**.

Return of Unacceptable Cost Reports

Failure to complete cost 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 1 TAC Section 355.111. Cost reports that are not completed in accordance with applicable rules and instructions will be returned for correction and resubmission. The return of the cost report will consist of un-certifying the file originally submitted via STAIRS which will re-open the cost report to allow additional work and resubmission by the contracted provider. Notification of the return will be sent through e-mail and certified mail. HHSC grants the provider a compliance period of no more than 15 calendar days to correct the contract violation. Failure to resubmit an **acceptable** corrected cost report by the due date indicated in the return notification will result in the recommendation of a vendor hold. Refer to 1 TAC Section 355.106(a)(2)

Amended Cost Reports

An interested party legally responsible for the conduct of the contracted provider may initiate an amendment no later than 60 days after the original due date. Provider-initiated amendment requests can be sent to: costinformationpfd@hhs.texas.gov. Request received that is not signed by an individual legally responsible for the conduct of the contracted provider, or received after the 60th day, will not be accepted. Failure to submit the requested amendment to the cost report by the due date is considered a failure to complete a cost report. Refer to 1 TAC Section 355.105(d)(1)(A)

Accounting Methods

All revenues, expenses, and statistical information submitted on cost 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 cost report, costs must have been accrued during the cost reporting period and paid within 180 days of the end unless the provider is under bankruptcy protection and has received a written waiver of the 180-day rule from HHSC PFD. Refer to 1 TAC Section 355.105(b)(1).

Cost Report Certification

Contracted providers must certify the accuracy of the cost report submitted to HHSC. Contracted providers may be liable for civil and/or criminal penalties if the cost 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 cost-reporting requirements. The Methodology Certification page advises preparers that they may lose the authority to prepare future cost reports if cost reports are not prepared in accordance with all applicable rules, instructions, and training materials.

Reporting Data/Statistics

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

Direct Costing

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

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 daycare, and accrued leave), attendant care staff salaries, 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 cost report is being completed. Daily timesheets documenting time are required for all attendant salaries directly charged to the cost report. If the employee only works for the provider in one program and one position type, the daily timesheet must document the start, end, and 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 cost reporting period and part of the payroll period does not fall within the cost 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 six days included in the cost-reporting period and eight days not included in the cost-reporting period, the provider could either review their payroll information to properly direct the cost, paid hours, and salaries for only the six days included in the cost-reporting period, or the provider could allocate 6/14th of the payroll period’s hours and salaries to the cost report. The method chosen must be consistently applied during each cost-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 Section 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 PFD. An indirect allocation method approved by some other department, program, or governmental entity (including Medicare, other federal funding sources, or state agencies) 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 administrative functions are more than likely shared across various business components, service delivery programs, or Medicaid contracts. Shared administration costs require allocation before being reported as central office costs on the cost report. The allocation method(s) used must be disclosed as the allocated costs are entered into STAIRS, and an allocation summary must be prepared and uploaded to support each allocation calculation.

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

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

facility-cost" allocation method, the cost report preparer needs to provide documentation that all facility costs were excluded.

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

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

A provider may have many costs shared between business components. For example, a PHC 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, nursing staff, clerical staff, administration costs, and other shared costs. Guidelines for the allocation of various expenses will be provided in each Step of the *Specific Instructions* as appropriate. Refer to 1 TAC Sections 355.102(j) and 355.105(b)(2)(B)(v).

Recordkeeping

Providers must maintain records that are accurate and sufficiently detailed to support the legal, financial, and statistical information contained in the cost report. These records must demonstrate the necessity, reasonableness, and relationship of the costs to the provision of resident care or the relationship of the central office to the individual provider. These records include but are not limited to, accounting ledgers, journals, invoices, purchase orders, vouchers, canceled checks, timecards, payrolls, mileage and flight logs, loan documents, insurance policies, asset records, inventory records, organization charts, time studies, functional job descriptions, work papers used in the preparation of the cost 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. Refer to 1 TAC Sections 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. A detailed written description of actual duties, functions, and responsibilities;

B. Documentation substantiating that the services performed are not duplicative of services performed by other employees;

C. Timesheets or other documentation verifying the hours and days worked; (NOTE: this does not mean the number of hours, but actual hours of the day);

D. The amount of total compensation paid for these duties, with a breakdown of regular salary, overtime, bonuses, benefits, and other payments;

E. Documentation of regular, periodic payments and/or accruals of the compensation;

F. Documentation that the compensation was subject to payroll or self-employment taxes; and

G. A detailed allocation worksheet indicating how the total compensation was allocated across business components receiving the benefit of these duties.

Refer to 1 TAC Section 355.105(b)(2)(B)(xi).

Failure to Maintain Records

Failure to maintain all work papers and any other records that support the information submitted on the cost 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 1 TAC Section 355.111 of this title (relating to Administrative Contract Violations). Also refer to 1 TAC Section 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 cost 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 PFD on cost reports constitutes an administrative contract violation. Refer to 1 TAC Section 355.106(f)(2).

Field Audits and Desk Reviews of Cost Reports

Each Medicaid cost report is subject to either a field audit or a desk review by HHSC Cost Report Review Unit (CRRU) Audit staff to ensure the program's fiscal integrity. Cost 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 Section 355.105(b)(2)(B)(xviii).

Notification of Exclusions and Adjustments

HHSC PFD notifies the provider by e-mail of any exclusions and/or adjustments to items on the cost report. See **Step 12** and **Step 13.** The Cost Report Review Unit (CRRU) furnishes providers with written reports of the results of field audits. Refer to 1 TAC Section 355.107.

Informal Review of Exclusions and Adjustments

A provider who disagrees with HHSC PFD's adjustments has the right to request an informal review of the adjustments. Requests for informal reviews must be received by HHSC PFD 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. Refer to 1 TAC Section 355.110.

Common Cost Reporting Errors

The following is a list of some of the more common errors found on cost reports. These errors and others can be avoided by carefully following the cost report instructions and rules concerning allowable and unallowable expenses.

1. Cost reports are submitted on a cash basis rather than on an accrual basis of accounting for providers who are not governmental entities.
2. Costs that should be reported separately are combined; for example, the costs incurred for building, vehicle, and general liability insurance are incorrectly all reported in the same item.
3. Incorrect related-party staff/contractor information and failure to include an organization chart that clearly identifies each owner-employee, other related-party employees, or related-party contractor, along with each business entity/component.
4. Costs are misclassified; for example, the lease expense for a photocopier is incorrectly included in **Step 8.f**. Operations Supplies line instead of being correctly reported in the Rent/Lease – Departmental Equipment and Other line.
5. Hours and expenses reported in the incorrect staff-type line items.
6. Costs for land are incorrectly included in building historical costs for depreciation purposes.
7. Administrative costs shared by several contracts or business components are reported as Program Administration and Operations Expense rather than Central Office expense.
8. Detailed asset listing/depreciation schedule was not uploaded, and the summary method of reporting was used in **Step 8.e**.
9. 10% salvage value for building was not removed in calculating depreciation costs; summary method of reporting was used in **Step 8.e**.
10. Vehicle depreciable value was not limited for luxury vehicles.

11. Contract labor costs were not included when calculating allocation percentages using the salaries and labor methods.

Common Errors Regarding Unallowable Costs

1. Expenses are incorrectly reported for activities that are not related to contracted services.
2. Incorrect reporting of personal expenses for items such as personal lunches, personal use of a company vehicle or cellular phone, and personal travel expenses not related to employee business travel.
3. Salaries or expenses incorrectly reported for relatives or owners who do not actually work for or perform services for, the contract.
4. Unallowable promotional advertising incorrectly included in reported advertising costs as an allowable cost.
5. Erroneous reporting as allowable costs those unallowable dues or membership fees to organizations whose primary emphasis is not related to contracted services, for example, the Chamber of Commerce, the Lions Club, or Veterans of Foreign War (VFW) organizations.
6. Incorrect reporting (with allowable expenses) of unallowable penalties or fines (such as non-sufficient funds (NSF) fees or late payment penalties).
7. Incorrectly expensing bad debts as "Other" costs.
8. Incorrect reporting of payroll taxes. For example, incorrectly reporting FICA/Medicare taxes at greater than 7.65% of the total reported salaries (excluding central office salaries).
9. Erroneously expensing capital expenditures (rather than properly depreciating them) for items such as roofs, air-conditioning systems, vehicles, sidewalks, and paving of the parking lot.
10. Failure to disclose related-party transactions, such as the lease of a building or vehicles.
11. Misstatement of allocated costs because the allocation method used was inappropriate (e.g., based on revenue) or based on unreasonable criteria (e.g., administration salary allocations based on square footage).
12. Overstatement of depreciation costs because the land cost was incorrectly included with the historical cost of building.
13. Overstatement of building depreciation expense because 10% salvage value was not removed.

14. Overstatement of transportation equipment depreciation expense because depreciable value of luxury vehicle was not limited.
15. QIPP/UPL Facilities - Incorrectly reported allocated central office costs for management company that was not related to the county or hospital district.
16. QIPP/UPL Facilities - Incorrectly reported building rent/lease as related party when building was related to a non-related party management or operating company but was not owned by the county or hospital district.

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 an 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 end 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 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 Section 355.105(b)(1). If accrued expenses are not paid within 180 days after the fiscal year-end, and HHSC has approved no written exception to the 180-day rule, the cost is unallowable and should not be reported on the cost report. If the provider's cost report is submitted 180 days after the provider's fiscal year-end and the provider later determines that some of the accrued costs have not been paid within the required 180-day period, the cost report preparer should submit a revised cost report with the unpaid accrued costs removed.

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. If applicable, administration costs include office and central office costs (i.e., shared administrative costs properly allocated to this program). Administration costs are not direct care costs.

Allocation - A method of distributing costs on a pro-rata basis. For more information, see Cost Allocation Methods in the General Instructions section and the Cost Report Training materials. Refer to 1 TAC Section 355.102(j).

Allowable and Unallowable Costs - In accordance with 1 TAC Section 355.102(a), "Allowable and unallowable costs, both direct and indirect, are defined to identify expenses that are reasonable and necessary to provide contracted client care and are consistent with federal and state laws and regulations."

In accordance with 1 TAC Section 355.102(f)(1), 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. In determining the reasonableness of a given cost, the following are considered:

- the restraints or requirements imposed by arm's-length bargaining, i.e., transactions with nonowners or other unrelated parties, federal and state laws and regulations, and contract terms and specifications; and
- the action that a prudent person would take in similar circumstances, considering his responsibilities to the public, the government, his employees, clients, shareholders, and members, and the fulfillment of the purpose for which the business was organized.

Beyond the cost's reasonability, an allowable cost must also be necessary. In accordance with 1 TAC Section 355.102(f)(2), "Necessary" refers to the relationship of the cost, direct or indirect, incurred by a provider to the provision of contracted client care. Necessary costs are direct and indirect costs that are appropriate in developing and maintaining the required standard of operation for providing client care in accordance with the contract and state and federal regulations. In addition, to qualify as a necessary expense, a direct or indirect cost must meet all of the following requirements:

- the expenditure was not for personal or other activities not directly or indirectly related to the provision of contracted services;
- the cost does not appear as a specific unallowable cost in 1 TAC Section 355.103 of this title;
- if a direct cost, it bears a significant relationship to contracted client care. To qualify as significant, the elimination of the expenditure would have an adverse impact on client health, safety, or general wellbeing;
- the direct or indirect expense was incurred in the purchase of materials, supplies, or services provided to clients or staff in the normal conduct of operations to provide contracted client care;
- the direct or indirect costs are not allocable to or included as a cost of any other program in either the current, a prior, or a future cost-reporting period;
- the costs are net of all applicable credits;
- allocated costs of each program are adequately substantiated; and
- the costs are not prohibited under other pertinent federal, state, or local laws or regulations.

Unallowable costs are costs that are neither reasonable or necessary and should not be reported on the Medicaid cost report per 1 TAC Section 355.102(g]). Providers may incur these costs but these costs cannot be considered as part of HHSC's rate determination processes.

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 asset's useful life. This may include amortization of deferred financing charges on the financing or refinancing of the purchase of the building, building improvements, building fixed equipment, leasehold improvements and/or land improvements. The amortization of goodwill is an unallowable

cost. The amortization of a Medicaid contract's purchase price (as opposed to the purchase price of the physical facility) is an unallowable cost. For additional information, see instructions for **Step 8.e.** Refer to 1 TAC Section 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 the 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 the *Specific Instructions* for Schedule G and the definition of *Routine Services*.

Applied Income - The portion of the daily payment rate the individual pays in residential programs. The 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 cost report. Refer to 1 TAC Section 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). Each separate contract with the state of Texas is usually considered a separate business component/entity. Each component code within a program is considered a separate business component for the IID programs. 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 shared administrative functions require allocation across more than one business. Central office costs are also known as allocated shared administrative costs. A separate corporation or partnership could provide the shared administrative functions, 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. Refer to 1 TAC Section 355.103(b)(7).

Certified Nurses 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 that are engaged in activities other than the provision of Medicaid program services in the state of Texas. This means that the business components could:

- Be located within or outside of Texas;
- Provide services other than the Medicaid services covered by this cost report, and
- Provide services that 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). It may involve an additional Controlling Entity that owns all members of the combined entity.

Common Ownership - This 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*. Refer to 1 TAC Section 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. Refer to 1 TAC Section 355.103(b)(1).

Compensation of Owners and Related Parties - Compensation includes cash and non-cash forms 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. Refer to 1 TAC Section 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 labor hours must be associated with allowable contract labor costs as defined in 1 TAC Section 355.103(b)(2)(C).

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 *Specific 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 cost 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 cost 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 considered to be related through control to their directors in common. Refer to 1 TAC Sections 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*.

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

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.** Refer to 1 TAC Section 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 without a differential in pay between functions 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 not 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.

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 cost report. See instructions for **Step 8** for instructions on the removal of goodwill.

Legend Drug (prescription drug) - Any drug that requires an order from a practitioner (e.g., physician, dentist, nurse practitioner) before it may be dispensed by a pharmacist or any drug that may be delivered to a resident by a practitioner 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 a 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. Refer to 1 TAC Sections 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. Refer to 1 TAC Section 355.102(f)(2).

Net Expenses - Gross expenses less any purchase discounts or returns and purchase allowances. Only net expenses should be reported on the cost report. Refer to 1 TAC Sections 355.102(k) and 1 TAC 355.103(b)(18)(D)

Non-Contracted Beds – Licensed nursing beds that are not contracted to provide nursing facility services to Medicaid residents. Medicare-only or private-pay residents may occupy these licensed beds. Beds licensed as personal care beds are not non-contracted beds; no statistics, revenues, or costs related to personal care beds should be reported on a Medicaid cost report.

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. Refer to 1 TAC Sections 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 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 cost 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 cost report. Also known as contracted provider. See definitions for *Component Code, Contracting Entity*, and *Cost Report Group.*

Purchase Discounts - Discounts such as reductions in purchase prices resulting from prompt payment or quantity purchases, including trade, quantity, and cash discounts. Trade discounts 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 cost report. Refer to 1 TAC Section 355.102(k).

Purchase Returns and Allowances - Reductions in expenses resulting from returned merchandise or merchandise that is damaged, lost, or incorrectly billed. Expenses must be reduced by these returns and allowances prior to being reported on the cost report. Refer to 1 TAC Section 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. Refer to 1 TAC Section 355.102(f)(1).

Refunds and Allowances - Reductions in revenue resulting from overcharges.

Reimbursement Methodology - Rules by which HHSC determines daily payment rates for nursing facility services that are statewide and uniform by class of service. Refer to 1 TAC Sections 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. Refer to 1 TAC Section 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. Refer to 1 TAC Section 355.102(i).

Related-Party Transactions - The purchase/lease of buildings, facilities, services, equipment, goods, or supplies from the contracted provider's central office, an individual related to the provider by common ownership or control, or an organization related to the provider by common ownership or control. Allowable expenses in related-party transactions are reported on the cost report at the cost to the related party. However, such costs must not exceed the price of comparable services, equipment, facilities, or supplies that could be purchased/leased elsewhere in an arms-length transaction. Refer to 1 TAC Section 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. Routine services include 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 Section 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 on the hours worked on the safety program (from actual timesheets or time studies). These safety program costs should be reported as Administration Costs.

Self-insurance – See Appendix E. Also refer to 1 TAC Section 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 before beginning 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 identified as organization costs or construction costs must be appropriately classified as such and excluded from startup costs. Allowable startup costs should be amortized over not less than 60 consecutive months. The startup costs are unallowable if the business component

or corporation never commences actual operations or if the new contract/program never delivers services. Refer to 1 TAC Section 355.103(b)(20)(D).

Vendor Hold - HHSC rules specify that Medicaid payments from HHSC may be withheld from contracted providers in certain specific situations, as described in 1 TAC Section 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 the definition of *Safety Program.*

Common Questions/Issues Regarding the Proper Reporting of Direct Care Staff

1. The following functions are considered direct care functions if performed by a Director of Nurses (DON), Registered Nurse (RN), Licensed Vocational Nurse (LVN), Medication Aide, Restorative Aide, or Certified Nurses Assistant (CNA): completion of the Minimum Data Set (MDS) assessment forms; development of care plans; attendance at direct care training; charting, the nursing administration aspects of a DON's job, and classroom-based direct care training provided by the DON.
2. The following functions are not considered direct care functions: medical records; central supply; someone other than a DON presenting classroom-based direct care training; quality assurance nurse consultant from the central office; and time spent filling water pitchers and changing linen by individuals other than RNs, LVNs, Medication Aides, Restorative Aides, and CNAs.
3. Does paid time off for direct care staff (e.g., paid vacation, paid sick leave) count as direct care time for this report? Yes, but if it is associated with an individual performing more than one function, it needs to be allocated. If a staff person "cashes in" his/her paid time off instead of taking leave, the time associated with this leave is not to be reported on this report. The compensation received as a result of "cashing in" is treated as a bonus and should be reported in the period in which it is subject to payroll taxes.
4. Pay for being "on-call" is reported as salaries by employee type, but only on-call hours actually worked performing direct care functions can be reported as time. For example, if an RN was on call for an entire weekend and received $200 as on-call compensation, the total $200 would be reported as salary 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.
5. Graduate Vocational Nurses (GVNs) should be reported as LVNs.
6. Unpaid overtime hours that meet all the other requirements to be reported as direct care staff time may be reported if they are properly documented. Unpaid overtime hours should be reported at the highest level of licensure or certification the individual working the overtime possesses. For example, if an RN DON works four hours unpaid overtime after the end of her shift, filling in for an absent Medication Aide, the four hours should be reported as RN time. Since the overtime is unpaid, no associated compensation should be reported. Compensation costs may not be imputed for unpaid overtime hours. Volunteer time should not be included on this report.

7. Paid overtime that meets all the other requirements to be reported as direct care staff time may be reported if it is properly documented. Paid overtime hours and compensation should be reported at the highest level of licensure or certification the individual working the overtime possesses.

8. Nurses that are also schedulers, infection control, facility-based quality assurance nurses, and CNAs that drive vans must spend at least 50% of their time on direct care functions to report 100% of their paid hours and salaries as direct care. To document the 50+%, the employee should perform a one-month functional time study (i.e., maintain daily timesheets for an entire month). Such a functional study should be completed at least annually. Otherwise, the employee must maintain daily, continuous timesheets to directly charge as direct care only those hours/salaries applicable to direct care functions. Time spent driving a van is not considered direct care time.

9. Respiratory therapists providing direct care in facilities receiving the ventilator and/or pediatric tracheotomy supplemental payments may be counted as LVNs.

10. Hours and wages for nurse aides in a Nurse Aide Training and Competency Evaluation Program (NATCEP) can only be reported as direct care if the nurse aide has completed at least the first 16 hours of NATCEP training. Any hours and wages associated with time worked before 16 hours of NATCEP training are completed (e.g., time spent as a hospitality aide or receiving the first 16 hours of NATCEP training) is to be reported as Other Resident Care Staff – Nonprofessional hours and wages in items **Step 6.d**.

For further information, see 1 TAC Section 355.308(a)

Detailed Instructions

General System Navigation

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

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

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

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

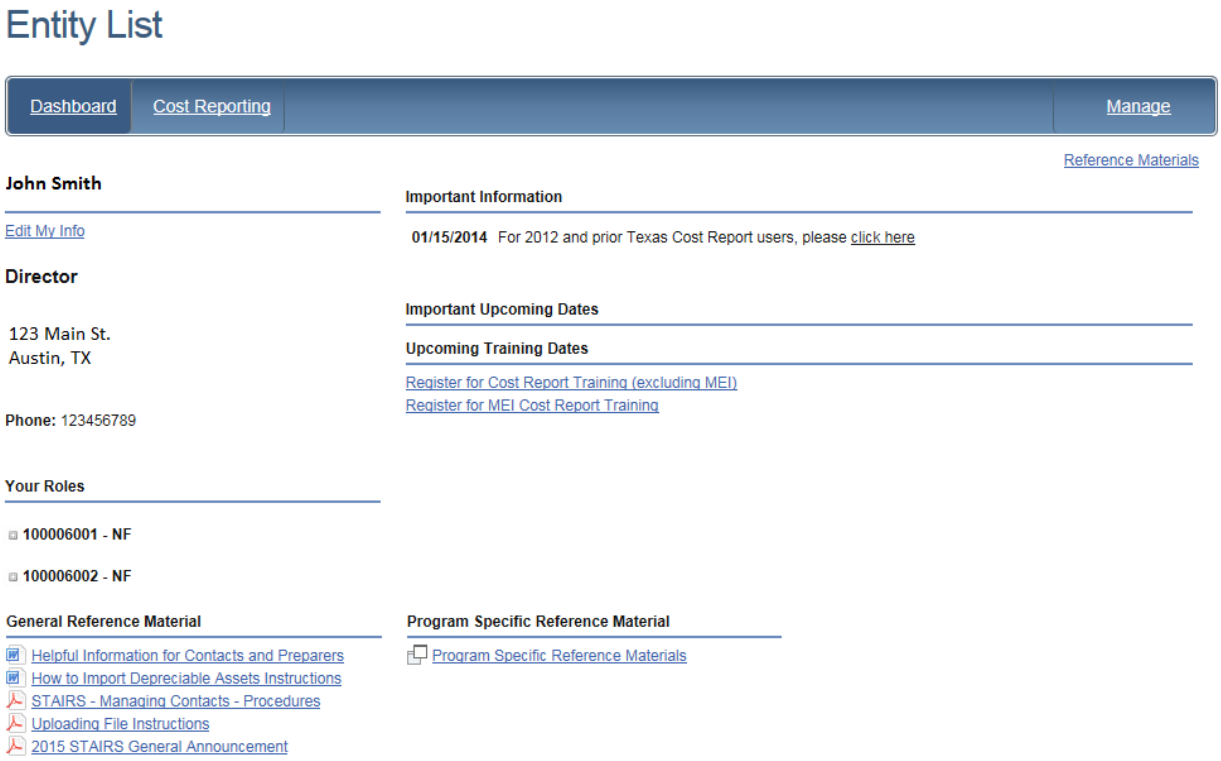
Save and Return: Saves the current data and returns to the prior level screen.

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

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

Data Entry Fields: Because the NF Cost Report contains costs for multiple programs, and not all services are available in each of the programs included in the report, certain data entry fields in **Step 5** and **Step 6** will not apply to all programs. When a service or step applies only to certain programs and the NF Cost Report does not include a contract for that program, that data entry field or step will be disabled. Please see the Instructions for **Step 5** and **Step 6** for additional information.

User Interface and Dashboard



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

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

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 contract number and program, for example, Contract Number 001234567 for Nursing Facility (NF), then there will only be one option to click on the initial Cost Reporting page. If the user has access permission for more than one contract number and/or program, for example, Contract Number 001234567 for NF and Contract Number 001234568 for Residential Care, then the user will need to choose the contract number and report in which the user wishes to work.

Step 1. Combined Entity Identification

Purpose

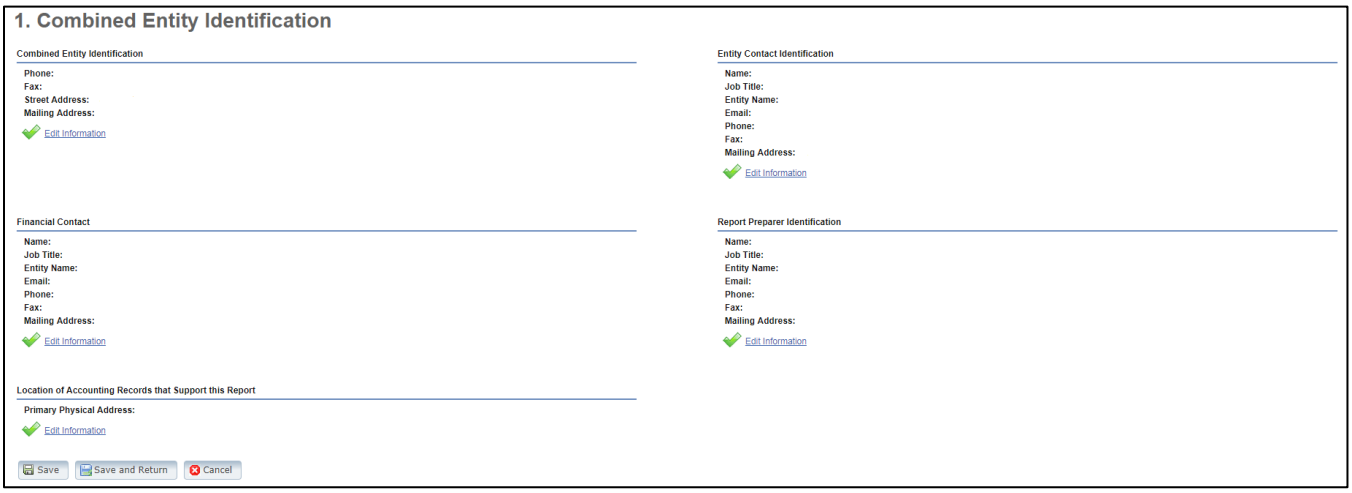
The purpose of this section is to gather contact information so that HHSC PFD can contact provider/preparer/etc., during the cost report review. It is important to verify that all contact information is correct to ensure that provider receives all review correspondence. Step 1 fields will either be auto-populated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

How HHSC PFD uses the information?

The HHSC PFD uses this information to obtain the documentation needed to address issues in the cost report review. We contact preparers and providers on a regular basis.

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

The preparer and certifier must review, update/enter, and verify the current information for the applicable contacts, as defined below, to ensure timely notifications.



Combined Entity Identification

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

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 cost report.

Financial Contact

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

Report Preparer Identification

In accordance with 1 TAC Section 355.102(d), it is the responsibility of each provider to ensure that each cost report preparer who signs the Cost Report Methodology Certification completes the required HHSC-sponsored cost report training. The STAIRS cost 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 training (detailed in the next paragraph) from HHSC for both the General and the Program Specific training will be able to complete a cost report in STAIRS. A list of preparers who have completed the training may be accessed through the HHSC 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 report is submitted. Such training is required every other year for the odd-year cost report in order for the preparer to be qualified to complete both that odd-year cost report and the following even-year cost report.

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

Location of Accounting Records that Support this Report

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

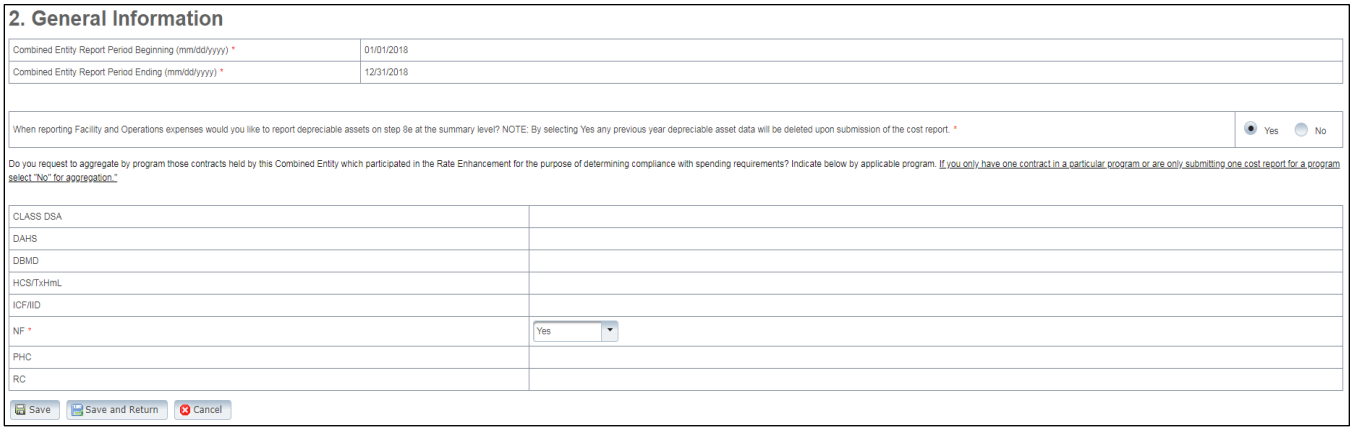
Step 2. General Information

Purpose

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

How HHSC PFD uses the information?

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



Combined Entity Reporting Period Beginning and Ending Dates

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

This reporting period should include the earliest date the combined entity had a contract with HHSC during the entity's fiscal year ending in 2020 and run through the earlier of the end of the combined entity's 2020 fiscal year or the last date on which the combined entity held a contract with HHSC. 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 cost report will be rejected as unacceptable and returned for proper completion.

To change the provider's corporate fiscal year for cost-reporting purposes, the provider must send a written notification to HHSC Provider Finance. The notification should include the name of each affected contracted provider, all 3-digit Cost Report Group Codes, and all 9-digit contract numbers. The notification should also include documentation from the IRS approving the change. The provider must state the effective date of the change and the previous corporate fiscal year. HHSC Provider Finance will notify the provider in writing about how to handle each month for cost-reporting purposes since no cost report can cover more than 12 months. If the provider faxes the notification, it must be followed with an original in the mail. For contracting purposes, HHSC Provider Enrollment must be notified on the appropriate forms.

When reporting Facility and Operations expenses, would you like to report depreciable assets on Step 8.e., at the summary level?

Regarding the reporting of depreciable assets, providers (with the exception of the 24-Hour Residential Child Care program) have the option of:

- Data entering each individual capital asset in Step 8.e. and allowing the system to determine the amount of straight-line depreciation applicable to the cost report;

OR

- Reporting the depreciation expense per category at the summary level in Step 8.e.

Note:

If a provider chooses to data enter each of their individual capital assets in **Step 8.e.,** in their 2020 NF Cost Report, the depreciable asset information will automatically populate from the last cost report submitted after the initial entry. If a provider later chooses to enter depreciation at the summary level on subsequent cost reports, any previously entered depreciable asset data will be deleted upon submission of their cost report.

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

If an entity operates two or more component codes that participate in the Direct Care Staff Compensation Rate Enhancement program, they may choose to have this group of contracts by program reviewed in the aggregate for the purposes of determining compliance with spending requirements. If you only have one contract in a particular program or are only submitting one cost report for a program, then select "No".

Step 3. Contract Management

Purpose

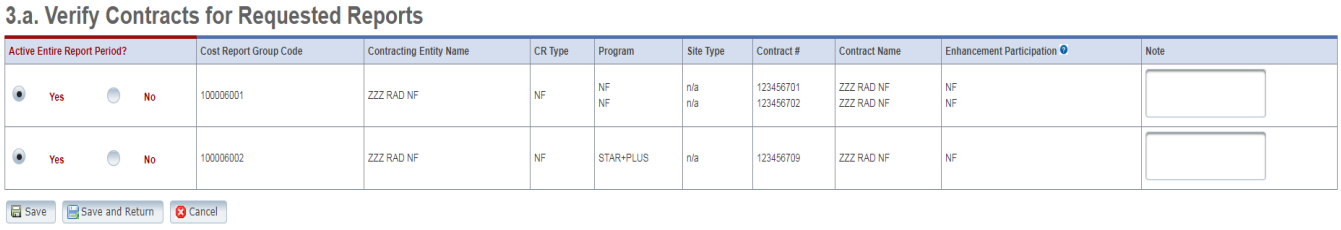
- The purpose of this step is to collect information about the combined entity's business components.
- Step 3.a. details the combined entity's Medicaid fee-for-service contracts or STAR+PLUS contracts.
- Step 3.b. details the combined entity's other contracts with the state of Texas, excluding contracts in Step 3. a.
- Step 3.c. details all other business components or contracts not listed in Steps 3.a. or 3.b.

How HHSC PFD uses the information

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

How to complete Step 3

Step 3.a. Verify Contracts for Requested Reports


3.a. Verify Contracts for Requested Reports

Active Entire Report Period?	Cost Report Group Code	Contracting Entity Name	CR Type	Program	Site Type	Contract #	Contract Name	Enhancement Participation	Note
Yes / No	100006001	ZZZ RAD NF	NF	NF NF	n/a n/a	123456701 123456702	ZZZ RAD NF ZZZ RAD NF	NF NF	
Yes / No	100006002	ZZZ RAD NF	NF	STAR+PLUS	n/a	123456709	ZZZ RAD NF	NF	

Save | Save and Return | Cancel

This list carries over from year to year. It is a list of all NF program contracts operated by the provider's combined entity grouped by Cost Report Group Codes. For each cost report group, the preparer must indicate in the left-most column whether the contracts in the Cost Report Group were active during the entire cost 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 component codes/contracts should be added to the prepopulated list or that a component code/contract included in the prepopulated list should be deleted, contact HHSC PFD 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 cost 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)

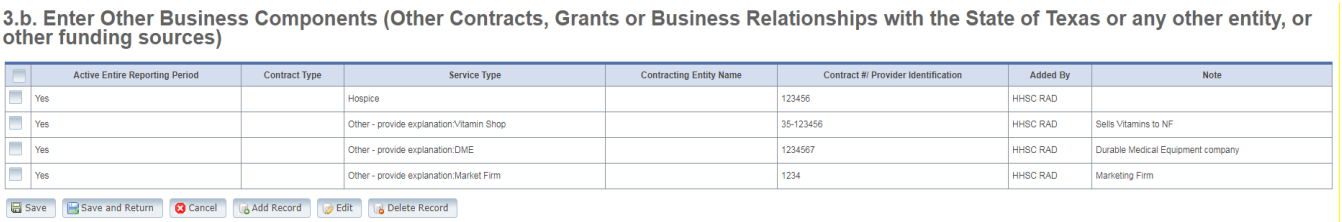
This is a list of all ATexas and out-of-state business relationships in which the combined entity is involved not already listed in **Step 3.a.** and must include all other contracts (i.e.: Medicare, CACFP, Hospice, Veterans Administration, and StarKids, etc.).

STAR+PLUS contracts are not to be listed in Step 3b. If all of your STAR+PLUS contracts were not already listed in Step 3a, do not add them here on Step 3b but instead contact HHSC immediately at costinformationpfd@hhs.texas.gov us so HHSC can add them to Step 3a.

This list carries over from year to year. It is a list of all Texas and out-of-state business relationships in which the combined entity is involved not already listed in **Step 3.a.** 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 cost report period. If the answer to this question for a specific contract, grant or business relationship is "No", then an explanation must be entered in the Note column.

A preparer can add, edit or delete items from this list. Clicking Add will lead to the Add Contracts screen where all the necessary information can be added. See graphic below. Any changes to this list will trigger changes to the cost 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 cost report period? – If "No" is chosen, provider will be required to enter an explanation in the Notes section.

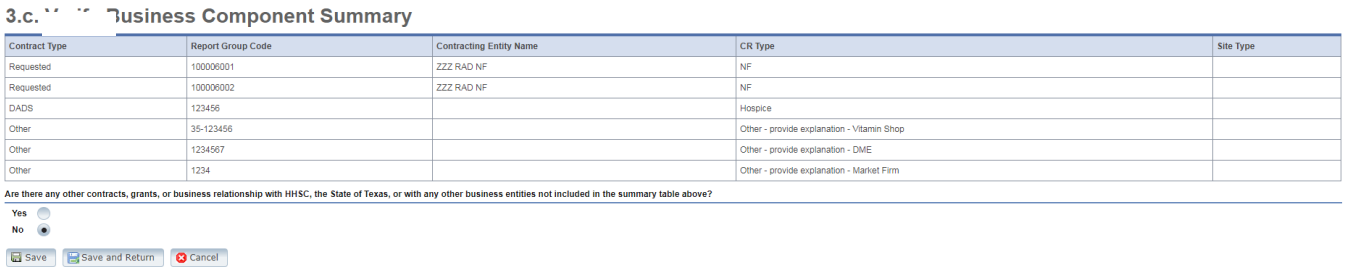
B. Contract Type – The contract type will drive available options in Service Type below. Contracts which are neither state nor Medicare, such as contracts with related durable medical equipment entities, will be designated as "Other".

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


3.c. Business Component Summary

Contract Type	Report Group Code	Contracting Entity Name	CR Type	Site Type
Requested	100006001	ZZZ RAD NF	NF	
Requested	100006002	ZZZ RAD NF	NF	
DADS	123456		Hospice	
Other	35-123456		Other - provide explanation - Vitamin Shop	
Other	1234567		Other - provide explanation - DME	
Other	1234		Other - provide explanation - Market Firm	

Are there any other contracts, grants, or business relationship with HHSC, the State of Texas, or with any other business entities not included in the summary table above?

Yes
No

Save | Save and Return | Cancel

This screen lists all cost 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

Purpose

The purpose of Step 4 is to collect general information about the contracted entity that delivered services during the reporting period.

How do we use this information?

HHSC PFD uses this information for a variety of purposes in the financial examination and reports reconciliation processes. HHSC may also add questions to collect one-time information for events that impact provider costs.

How to complete Step 4

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

National Provider Identifier (NPI) #: Please contact HHSC at costinformationpfd@hhs.texas.gov if you believe this is not your current NPI number.	140, 141
Facility Identification #: Please contact HHSC at costinformationpfd@hhs.texas.gov if you believe this is not your current facility identification number.	N/A
Type of Ownership of Contracting Entity	**Proprietary (For Profit)** Sole Proprietor Partnership Limited Partnership Limited Liability Company "S" Corporation Corporation **Nonprofit Corporation** Owned or affiliated with religious organization Not owned or affiliated with religious organization **Nonprofit Association** Owned or affiliated with religious organization Not owned or affiliated with religious organization **Government** State County Municipal Special District Federal
Contracted Provider Report Period Beginning (mm/dd/yyyy)	08/01/2022
Contracted Provider Report Period Ending (mm/dd/yyyy)	05/01/2023
Is provider a participant in Direct Care Staffing Rate Enhancement for the entire reporting period for this accountability report group for NF services?	Yes
Was an accrual method of accounting used for reporting all revenues, expenses, and statistical information on this report except for where the instructions require otherwise?	---
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.	---
Do you choose to waive your right to mitigation of any recoupment amounts related to failure to meet spending requirements for the reporting period?	---
Did you provide units of service during this cost reporting period?	---

National Provider Identifier (NPI)

The NPI must be associated with the contracts listed in Step 3a. The NPI number is prepopulated. The cost report needs to reflect all NPIs associated with units reported on the report.

HHSC uses the NPIs to validate paid units of service entered into Step 5. It is very important that this number be accurate. If not correct, please contact costinformationpfd@hhs.texas.gov.

Facility ID:

If you believe this is not your current facility identification number, please contact costinformationpfd@hhs.texas.gov.

Type of Ownership of Contracting Entity:

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

Contracted Provider Reporting Period Beginning and Ending Dates:

These dates represent the beginning and ending dates for the contracted provider's reporting period. For a contracted provider that submitted a cost report in a prior year, these dates will be based on the dates from the prior cost report. For a contracted provider that is reporting for the first time this year, the dates are based on the beginning date of the first contract and on the assumption that the provider is on a calendar fiscal year, so has an ending date of 12/31 of the cost report year. If these dates are not correct, contact HHSC PFD at costinformationpfd@hhs.texas.gov for assistance.

Beginning and Ending Dates When the Cost Report Group Did Not Have At Least One Contract Active for the Provider's Entire Fiscal Year Ending in 2020:

In situations where the cost report group did not have at least one contract active for the provider's entire fiscal year ending in 2020, the reporting period must match with HHSC records regarding the effective dates of the provider's current contract(s).

If the provider's reporting period is less than twelve months, the cost report preparer must properly report only those statistics, revenues and expenses associated with the reporting period. For example, if the provider's reporting period was 2/1/2020 through 12/31/2020, it is unacceptable for the cost report preparer to report 11/12 of the provider's annual days of service, annual revenues, and annual expenses. Instead, the cost report preparer should only report information related to the reporting period, meaning that units of service, revenues, and costs related to the month of January 2020 are not to be included anywhere on the cost 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 cost report preparer properly report only those statistics (i.e., units of service), revenues, and costs associated with the actual cost-reporting period. If, for example, the provider's cost-reporting period was 8/15/2020 through 12/31/2020, it is unacceptable for the cost report preparer to report 37.8% of the provider's total days of service, revenues, and costs for the year. Rather, the cost report preparer must report the days of service, revenues and costs associated only with the period 8/15/2020 through 12/31/2020. Since the month of August is partially reported (i.e., 8/15 - 8/31), the cost report 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 Provider Finance Customer Information Center.

Is provider a participant in the NF Direct Care Staff Compensation Rate Enhancement for the entire reporting period for this Cost Report?

This answer will be prepopulated and based on whether the provider was a participant for the entire cost reporting period. If the prepopulated answer appears to be incorrect, please contact Provider Finance at costinformation@hhs.texas.gov.

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

Click either "Yes" or "No". If "No", provide a reason in the Explanation Box. For the definition of the accrual method of accounting, see the **Definitions** section. An accrual method of accounting must be used in reporting information on Texas Medicaid cost reports in all areas except those in which instructions or cost-reporting rules specify otherwise. Cost 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 Section 355.105(b)(1) for additional information on accounting methods.

Did the preparer(s) of this report review the most recently received audit 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 cost report preparer attach a reconciliation worksheet, with its foundation being the provider's year-end trial balance. Refer to 1 TAC Section 355.105(b)(2)(A).

Are you reporting Central Office expenses in this report?

Click either "Yes" or "No". If "Yes" is clicked, then upload the Central Office Allocation Methodology.

Are you reporting any allocated Non-Central Office Program Administration expenses?

Click either "Yes" or "No". If "Yes" is clicked, then the Non-Central Office Program Administration Allocation Methodology must be uploaded to the report. This situation

would occur when the Program Administrator is a Central Office employee, but directly charges their NF Program Administrator time to the program.

During the cost reporing period, was the facility Medicaid-decertified for any period of time?

If the facility was decertified for more than 30 days during the cost reporting period, the cost report should only cover the period subsequent to recertification. Costs accrued prior to and during the period of decertification are not to be included in the cost report, including costs to get recertified (e.g., professional fees or contracted administrative services).

Did you evacuate your facility due to a natural disaster that resulted in an issued state or federal emergency declaration (i.e. Hurricane)?

Click either "Yes" or "No". If "Yes" is clicked, then you will be prompted with the following request:

Please report all expenses above normal operating costs that are directly related to the natural disaster.

NOTE: Do NOT include costs related to the natural disaster anywhere else on this cost report.

Enter the total amount of expenses, above normal operating costs, that were incurred as a direct result of the natural disaster. Please round your reported amount to the nearest whole dollar.

Did you accept evacuees from a natural disaster that resulted in an issued state or federal emergency declaration (i.e. Hurricane) that did not become permanent residents in your facility?

Click either "Yes" or "No". If "Yes" is clicked, then you will be prompted with the following request:

Please report all expenses above normal operating costs that are directly related to the natural disaster.

NOTE: Do NOT include costs related to the natural disaster Harvey anywhere else on this cost report.

Enter the total amount of expenses, above normal operating costs, that were incurred as a direct result of the natural disaster. Please round your reported amount to the nearest whole dollar.

Upload an Organizational Chart.

Please upload the organizational chart for this report. The organizational chart must include employee name, postion, and related party information.

Did you experience a decrease in costs/utilization directly related to COVID-19?

HHSC acknowledges providers may have experienced a decrease in costs and/or utilization related to COVID-19. It is possible; a provider would experience a decrease in cost or utilization and also experience an increase in costs (see next question).

Click either "Yes" or "No".

Did you incur an increase in costs directly related to COVID-19? For example, some providers may have paid more for Personal Protective Equipment (PPE) – either because they had to purchase more PPE and/or it was more expensive.

Click either "Yes" or "No".

If "Yes" is clicked, you will be prompted with the following questions.

a) If Yes, was it an increase in unit of service?
   Click either "Yes" or "No".

b) If Yes, was it due to an increase in costs per unit of service?
   Click either "Yes" or "No".

Did you incur costs for a category(ies) that historically is not incurred when administrating/delivering this program/service? If Yes, please upload the excel template outlining these costs.

This question is specific to "new" costs that the provider historically has not incurred. Click either "Yes" or "No". If "Yes" is clicked, you will be prompted to upload an excel template outlining these costs and categories.

Did you receive local, state or federal grants directly related to COVID-19?

Click either "Yes" or "No". If "Yes" is clicked, you will be prompted to enter the total amount of the grant(s) received and used during the cost report year for either local, state, federal or other categories. Do not include grant funds you received that will either be returned to the granting authority or utilized in subsequent cost report years.

Please round your reported amount to the nearest whole dollar.

Step 5. Days of Service and Revenue Entry

Purpose

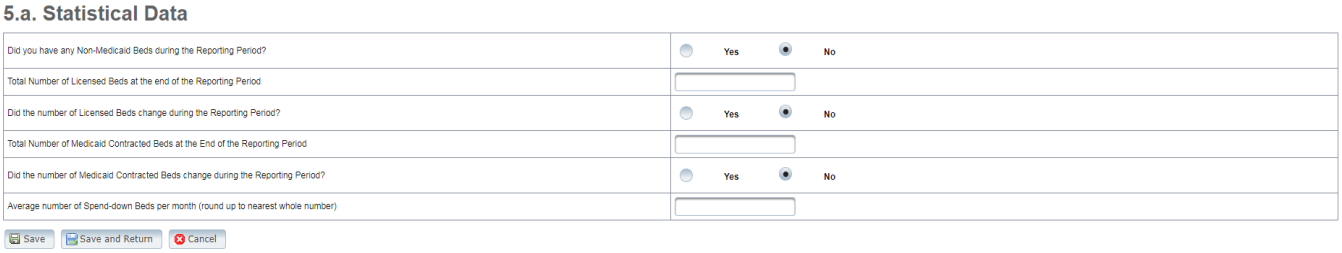
The purpose of Step 5 is to collect units of service information.

How do we use this information?

HHSC PFD uses this information to determine the contracted provider's revenue. Units of service are used in the report reconciliation process to determine staffing and spending compliance in the Rate Enhancement program and during rate-setting calculations.

How to complete Step 5

Step 5.a. Statistical Data


5.a. Statistical Data

Did you have any Non-Medicaid Beds during the Reporting Period?	Yes / No
Total Number of Licensed Beds at the end of the Reporting Period	
Did the number of Licensed Beds change during the Reporting Period?	Yes / No
Total Number of Medicaid Contracted Beds at the End of the Reporting Period	
Did the number of Medicaid Contracted Beds change during the Reporting Period?	Yes / No
Average number of Spend-down Beds per month (round up to nearest whole number)	

Save | Save and Return | Cancel

Did you have any Non-Medicaid Beds During the Reporting Period?

Answer "Yes" if there were any Units of Service in beds not contracted for Medicaid during the Reporting Period.

Total number of Licensed Beds at the End of the Reporting Period

Enter the total number of nursing beds the facility had licensed for resident care (both Medicaid-contracted and non-contracted) on the last day of the reporting period. Do not include facility beds licensed for non-nursing (i.e., personal care or hospital) care. Do not include unlicensed beds. The total of Licensed Beds cannot be less than the number of Medicaid-contracted beds.

Did the number of Licensed Beds change during the Reporting Period?

Indicate whether or not the number of licensed beds on the last day of the reporting period as reported above was applicable to every day of the reporting period. If it was not, check "YES."

Please upload a copy of your authorization letter from HHSC.

If "YES" was indicated, please upload a copy of the facility's authorization letter fromHHSC. If the letter is already in the Upload Center, click on the dropdown. If the authorization letter is a new file that had not been previously uploaded, click on "upload new file."

Number of licensed beds at beginning of reporting period

Enter the number of beds the facility had contracted for nursing care with the Texas Medicaid program at the beginning of the cost-reporting period. This number can be less but not greater than the number of total licensed beds for nursing care.

Date of change in number of licensed beds

If the number of licensed beds changed during the reporting period, enter the date of the change, and the new Number of licensed beds. If more than one change occurred during the reporting period, enter all dates of change and resulting number of licensed beds. STAIRS will use that information to calculate the Weighted Average (number of) Licensed Beds.

Total number of Medicaid Contracted Beds at the End of the Reporting Period

Enter the number of beds the facility had contracted for nursing care with the Texas Medicaid program at the end of the cost-reporting period. This number can be less but not greater than the number of total licensed beds for nursing care.

Did the number of Medicaid Contracted Beds change during the Reporting Period?

Indicate whether or not the number of Medicaid-contracted beds on the last day of the reporting period as reported above was applicable to every day of the reporting period. If it was not, check "YES."

Please upload a copy of your authorization letter from HHSC

If "YES" was indicated, please upload a copy of the facility's authorization letter from HHSC. If the letter is already in the Upload Center, click on the dropdown. If the authorization letter is a new file that had not been previously uploaded, click on "upload new file."

Number of Medicaid contracted beds at beginning of reporting period

Enter the number of beds the facility had contracted for nursing care with the Texas Medicaid program at the beginning of the cost-reporting period. This number can be less but not greater than the number of total licensed beds for nursing care.

Date of change in number of Medicaid contracted beds

If the number of Medicaid-contracted beds changed during the reporting period, enter the date of the change, and the new Number of Medicaid-contracted beds. If more than one change occurred during the reporting period, enter all dates of change and resulting number of Medicaid-contracterd beds. STAIRS will use that information to calculate the Weighted Average (number of) Medicaid Contracted Beds.

Average Number of Spend-down Beds per Month (round up to nearest whole number)

Calculate the average number of spend-down beds per month. If the number of spend-down beds changed during the month, the average number can be calculated by multiplying the number of beds by the number of days that the number of beds was in effect:

((# of beds x # of days) + (# of beds x # of days)) / days in month = Average Number of Spend-down Beds per Month

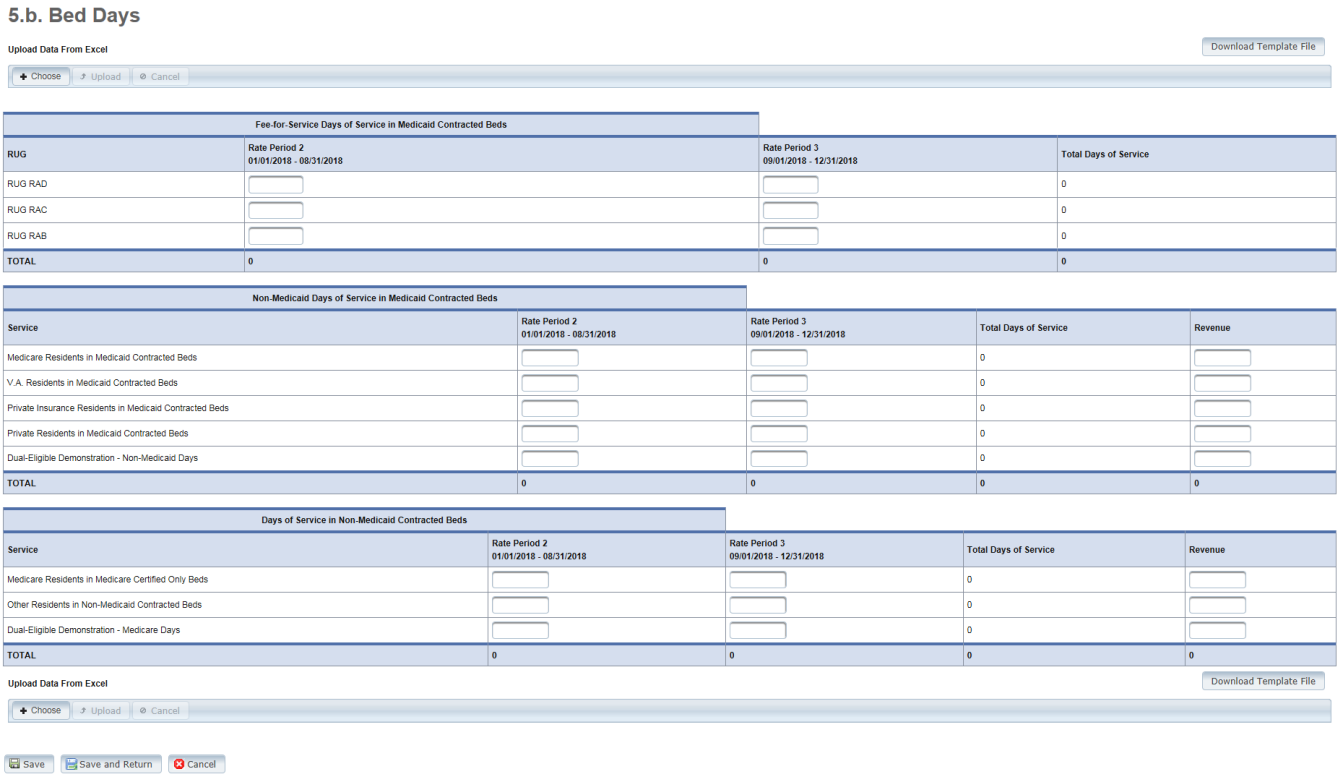
For example, if there were 10 spend-down beds for 15 days and 13 spend-down beds for 16 days (in a month with 31 days), the formula would be this:

((10 x 15) + (13 x 16)) / 31 = 11.54 beds, which should be rounded up to the nearest whole number = 12 spend-down beds per month.

Step 5.b. Bed Days

Reconciliation of Units of Service

HHSC reconciles units of service reported by the provider to paid units of service on the state billing and payment record. For all Fee-for-Service or STAR+PLUS units of service, the provider should report paid units for services delivered during the cost reporting period. Units paid from private (non-Medicaid) payer source can be reported under private pay units. If provider has billed additional units that were not paid by Fee-for-service Medicaid or STAR+PLUS or private payer source but are associated with costs incurred during the cost reporting period and reported in Step 6 or Step 8 on the cost report, these units should be reported under non-reimbursed.



In this screen 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 cost 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**..

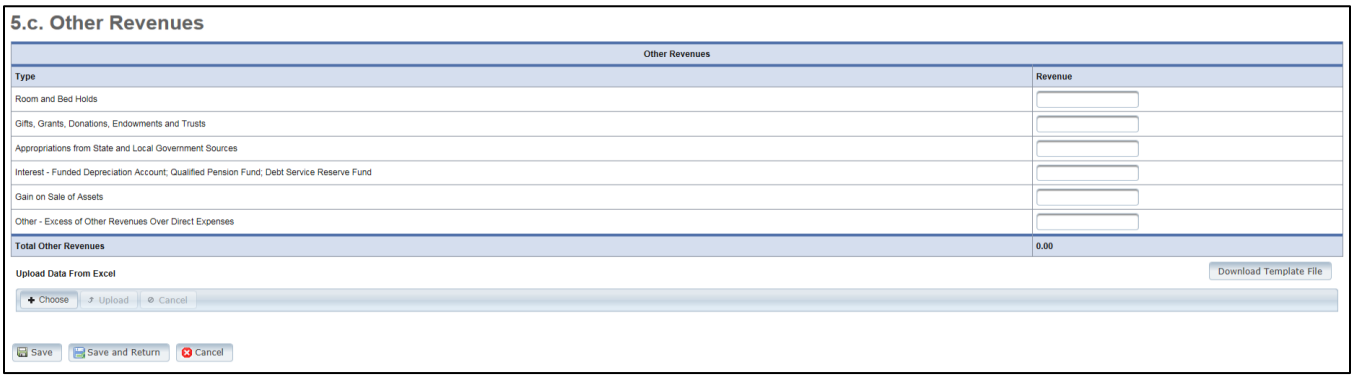
Days of service for HHSC residents under the Respite program should be reported in Step 5b Private Residents in Medicaid-Contracted beds or **Step 5.c.** Other Residents in Non-Medicaid Contracted Beds, depending upon whether the bed is contracted for Medicaid or not contracted for Medicaid.If the facility 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 5.b.** 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 screenshot shows a portion of the entry screen 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 are screenshots for the other tables included in **Step 5.b.**

Step 5.c. Other Revenues



Other revenues refer to income other than routine operating revenue as described above. Certain revenues from sources not related to resident care are to be reported. Do not include Ancillary Revenues. Ancillary revenues are revenues earned for providing non-routine services to residents for which a separate charge is customarily made (or has been historically made) in addition to the routine daily service charge (e.g., therapies, radiology, and laboratory). These revenues are reported only on Schedule G. Refer to the instructions for Schedule G).

Report routine operating revenues by type of bed and payment source. Include resident routine operating revenues from both Medicaid and non-Medicaid residents and Medicaid applied income (i.e., the amount paid by the Medicaid residents). Revenues from room or bed hold charges are to be reported as Room and Bed Holds in **Step 5.c.** and not included as resident routine operating revenue. Do not include ancillary revenues; ancillary revenues should be reported on Schedule G. Review the instructions for Schedule G to ensure that the revenues are properly classified as resident revenue or ancillary revenue since income received from routine service items such as disposable diapers, medical supplies, and dietary supplements are considered routine resident revenue and not ancillary revenue. If Medicare residents cannot segregate Medicare routine revenues from Medicare ancillary revenues, report the entire daily payment as Medicare routine revenue. *Routine operating revenues must be reported net of contractual adjustments.*

Routine operating revenues also include revenue from non-Medicaid residents for goods or services covered by the daily Resource Utilization Group (RUG-III) (RUG) payment rate for Medicaid residents. For example, suppose a Medicaid resident is provided a wheelchair for no extra charge. In that case, any revenue received from non-Medicaid residents for the use of a wheelchair is reported as resident revenue by type of resident, and the costs of the wheelchair are not offset on **Step 5.c.**

Resident revenue also includes the payment of late fees for accounts paid after the due date.

PRF revenue recognized during the cost report 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.c. of the cost or accountability report as applicable and will have no impact on allowable expenses reported.

Step 5.d. Days of Service Summary

Step 5.d. summarizes the Days of Service entered in Step 5.a. through 5.c.

Step 6. Wages and Compensation

Purpose

The purpose of Step 6 is to collect wages, compensation, and benefits information for the contracted provider's direct care, non-direct care, and administrative and central office staff.

How do we use this information?

HHSC PFD uses this information to determine the contracted provider's employee and contracted staff expenses. Staff expenses are used in the report reconciliation process to determine staffing and spending compliance in the Direct Care Staff Compensation Rate Enhancement program and rate-setting calculations.

How to complete Step 6

Step 6.a. General Information

Purpose

To collect staff related information.

Do you have any employee-related self-insurance expenses to report on this cost report? *	
Total number of central office staff employed by the controlling entity on the last day of the cost reporting period. *	Number Employed *
Total number of non-central office staff employed by the contracted provider on the last day of the cost reporting period.	Number Employed *
Do you have any Related-Party Wages and Compensation (Employee or Contractor) included in the Cost Report? *	

Do you have any employee-related self-insurance expenses to report on this cost report?

If "Yes," answer the next question. If "No," skip the next question and proceed with the rest of the questions.

Please select "Yes" or "No" for the following self-insurance expenses that you are reporting on this cost report.

If previous question was answered "Yes" then click on each self-insurance category reported

Total number of central office staff employed by the controlling entity on the last day of the cost-reporting period.

Total number of non-central office staff employed by the controlling entity on the last day of the cost-reporting period.

It is important to count employees only once. Enter the number of employees employed on the last day of the reporting period, not the number of full-time equivalents. Employees who worked in both a central office and a non-central office position should only be reported as central office employees. Do not include contract labor or consultants.

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

Click "Yes" or "No." See **Definitions**, *Related Party* to determine if the provider must report a related party. If the preparer clicks "Yes," then the Step on the main Wages and Compensation page called **Step 6.b.** will be activated for entry.

Staff Recruiting, Retention, and Benefits

The information entered in the following **Step 6.a.** tables will allow HHSC to evaluate the difficulties that providers are facing with staff recruitment and retention, especially for attendant staff, and will help HHSC assess how to help providers alleviate these issues going forward. Please note that the information in the following 6.a. tables asks for information from the calendar year, **not** your reporting period (unless your reporting period is also the calendar year).

Staff Recruiting Difficulties

This section asks the provider to assess whether staff recruiting has become more difficult or less difficult for your agency during the last **calendar year** (1/1/20xx - 12/31/20xx) compared with prior years.

For each of the listed staff Position Types, choose one of eight options:

- *Very easy*
- *Moderately easy*
- *Easy*
- *Neither easy nor difficult*
- *Difficult*
- *Moderately difficult*
- *Very difficult*
- *N/A (no staff of this type).*

Staff Recruiting Information

Staff Recruiting Difficulties	
Position Type	Level of difficulty in recruiting new staff from 1/1/2019 - 12/31/2019? Please select one option for each Position Type
Part-time Attendants and Drivers *	---
Full-time Attendants and Drivers *	---
Part-time Nurses (RNs, LVNs) *	---
Full-time Nurses (RNs, LVNs) *	---
Part-time Administrative, Operations and Central Office Staff *	---
Full-time Administrative, Operations and Central Office Staff *	---

Staff Retention Information

Staff Retention Information

Staff Retention Information												
			Number of staff who left:		Number of staff (Medicaid, Non-Medicaid & Private Pay combined) based on length of time employed or contracted with your agency							
Position Type	Number of staff (Medicaid, Non-Medicaid & Private Pay combined) on 12/31/2019	Number of staff vacancies on 12/31/2019	1/1/2019 - 6/30/2019	7/1/2019 - 12/31/2019	Less than 6 months	Between 6 and 12 months	Over 12 months	Average number of days to fill vacant positions (estimates accepted if unknown)	Number of attendants paid above the base wage rate of $8.00/hour on 12/31/2019	Current starting hourly wage for this type of position within your agency in 2019	Average hourly wage for this type of position after 2 years of employment	Percentage of work hours filled w/OT or non-scheduled staff (estimates accepted if unknown)
Part-time Attendants and Drivers										$	$	%
Full-time Attendants and Drivers										$	$	%
Part-time Nurses (RNs, LVNs)												
Full-time Nurses (RNs, LVNs)												
Part-time Administrative, Operations and Central Office Staff												
Full-time Administrative, Operations and Central Office Staff												
TOTAL	0	0	0	0	0	0						

Number of Staff (Medicaid, Non-Medicaid & Private Pay combined) on 12/31/20xx.

Enter the total number of staff members that were employed with your agency (by Position Type) on the exact date of 12/31/20xx.

Please note: the "TOTAL" number at the bottom of this column will need to match with the total number ("Total Staff by Length of Time") in the "Length of Time with your Agency" table.

Number of staff vacancies on [reporting period end]:

Enter the total number of staff members who left (resigned, terminated, quit, fired, etc.) during the first half of the year (1/1/20xx - 6/30/20xx), and then the total number of staff who left during the second half of the year (7/1/20xx - 12/31/20xx). This is also broken down by Position Type.

Number of staff who left during [reporting period start] – [reporting period halfway point]

Enter the total number of staff members who left (resigned, terminated, quit, fired, etc.) during the reporting period start date (1/1/20xx - 6/30/20xx), and then the total number of staff who left during the halfway point of the year (7/1/20xx - 12/31/20xx). This is also broken down by Position Type.

Number of staff who left [reporting period halfway point+ 1] – [reporting period end]

Enter the total number of staff members who left (resigned, terminated, quit, fired, etc.) during the first half of the year (1/1/20xx - 6/30/20xx), and then the total number of staff who left during the second half of the year (7/1/20xx - 12/31/20xx). This is also broken down by Position Type.

Number of staff (Medicaid, Non-Medicaid & Private Pay combined) based on length of time employed or contracted with your agency.

- Less than 6 months
- Between 6 and 12 months
- Over 12 months

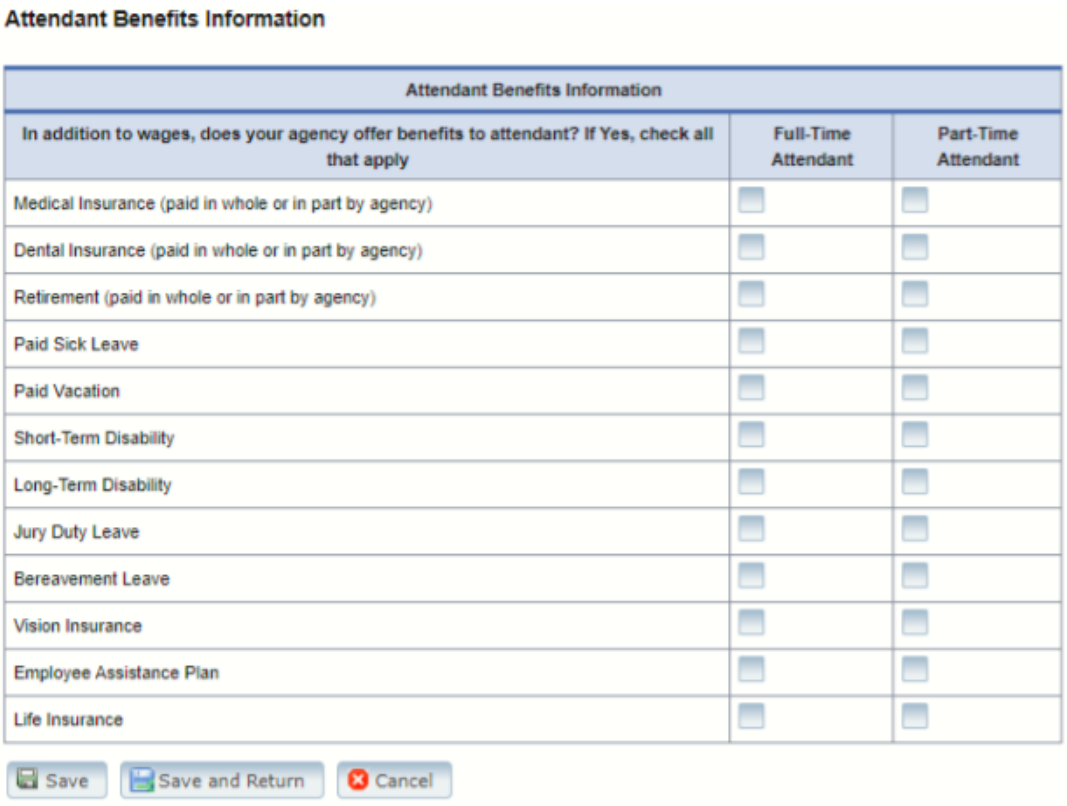
Average number of days to fill vacant positions (Estimates accepted if unknown)

Enter the average number of days required to hire new staff to fill a vacant position. If you do not know the exact number for this, please enter a thoughtful estimate.

Attendant Benefits Information

In addition to wages, does your agency offer benefits to attendants and drivers? If, yes, check all that apply

Click each box in order to add a check mark to the types of benefits that your agency offers to full-time and part-time staff. If your agency does not offer a particular benefit to your staff, please leave the field blank.



Attendant Benefits Information

Attendant Benefits Information		
In addition to wages, does your agency offer benefits to attendant? If Yes, check all that apply	Full-Time Attendant	Part-Time Attendant
Medical Insurance (paid in whole or in part by agency)	☐	☐
Dental Insurance (paid in whole or in part by agency)	☐	☐
Retirement (paid in whole or in part by agency)	☐	☐
Paid Sick Leave	☐	☐
Paid Vacation	☐	☐
Short-Term Disability	☐	☐
Long-Term Disability	☐	☐
Jury Duty Leave	☐	☐
Bereavement Leave	☐	☐
Vision Insurance	☐	☐
Employee Assistance Plan	☐	☐
Life Insurance	☐	☐

Save | Save and Return | Cancel

Step 6.b. Related-Party Wages and Compensation

Purpose

To collect related-party information.

This Step will be disabled, and the preparer will not be able to make entries if the answer is "No" to the question regarding Related Party Wages and Compensation in **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 a 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 the board of directors, membership in the 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.

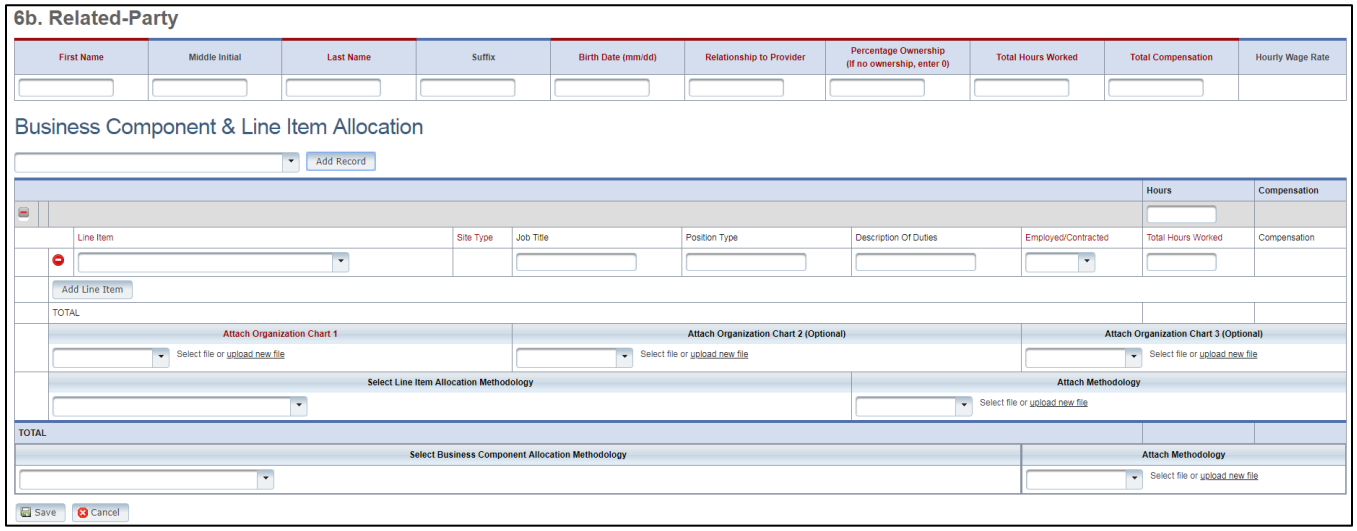
Note: This must be actual compensation without any adjustments based on related-party status. Any adjustments required by 1 TAC Section 355.105(i) will be made automatically in STAIRS during the audit process.
Hourly Wage Rate – Calculated figure based on Total Compensation divided by Total Hours Worked.

Note: If the preparer needs to delete a related party after filling out the data fields for A through J listed above, the 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

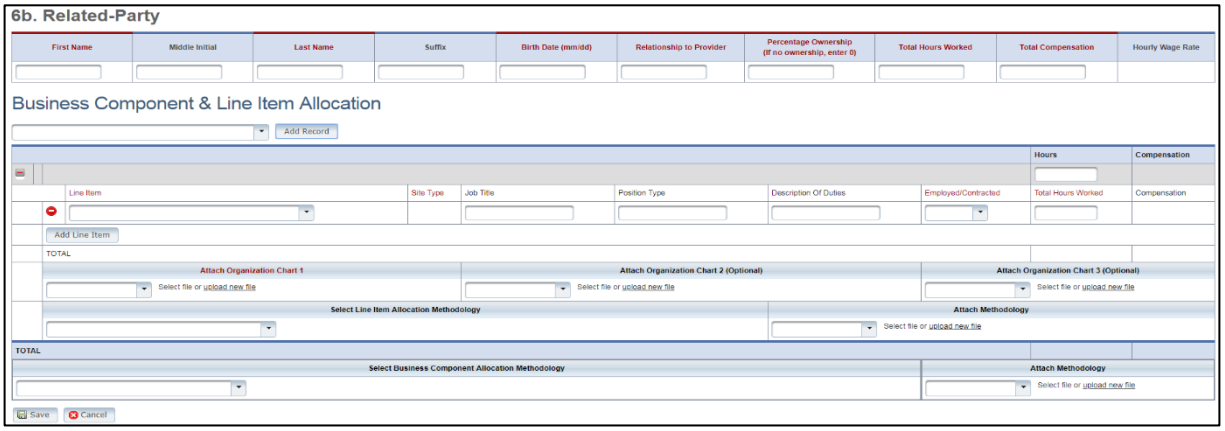
allocated, an allocation method must be chosen, and an allocation summary must be uploaded when prompted.



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

3. Enter Line Item Allocation(s)



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

A. Line Item – The drop-down menu includes all staff types reportable in this cost report. Direct Care staff types may only be used for staff who meet the definition of an attendant. See Definitions*, Direct Care*. Note both which staff can be classified as an attendant and which cannot.

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

C. 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.

D. Description of Duties – Provide a description of the duties performed by the related individual as they relate to the specific cost report or upload a copy of the person's written job description, providing a summary of how those duties relate to the specific cost report, and reference that uploads in this item.

E. Employed/Contracted –Select either Contracted or Employed. If the related party is compensated during the year as an employee and as a contractor for the same activity, then the hours contracted would have to be entered separately from the hours employed.

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

G. Organizational chart – Upload an organizational chart or select from the drop-down menu of documents that have already been uploaded.

H. 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 are multiple line items entered.

I. Business Component Allocation Methodology – After all business component line item allocations have been completed, reporting a related party in multiple business

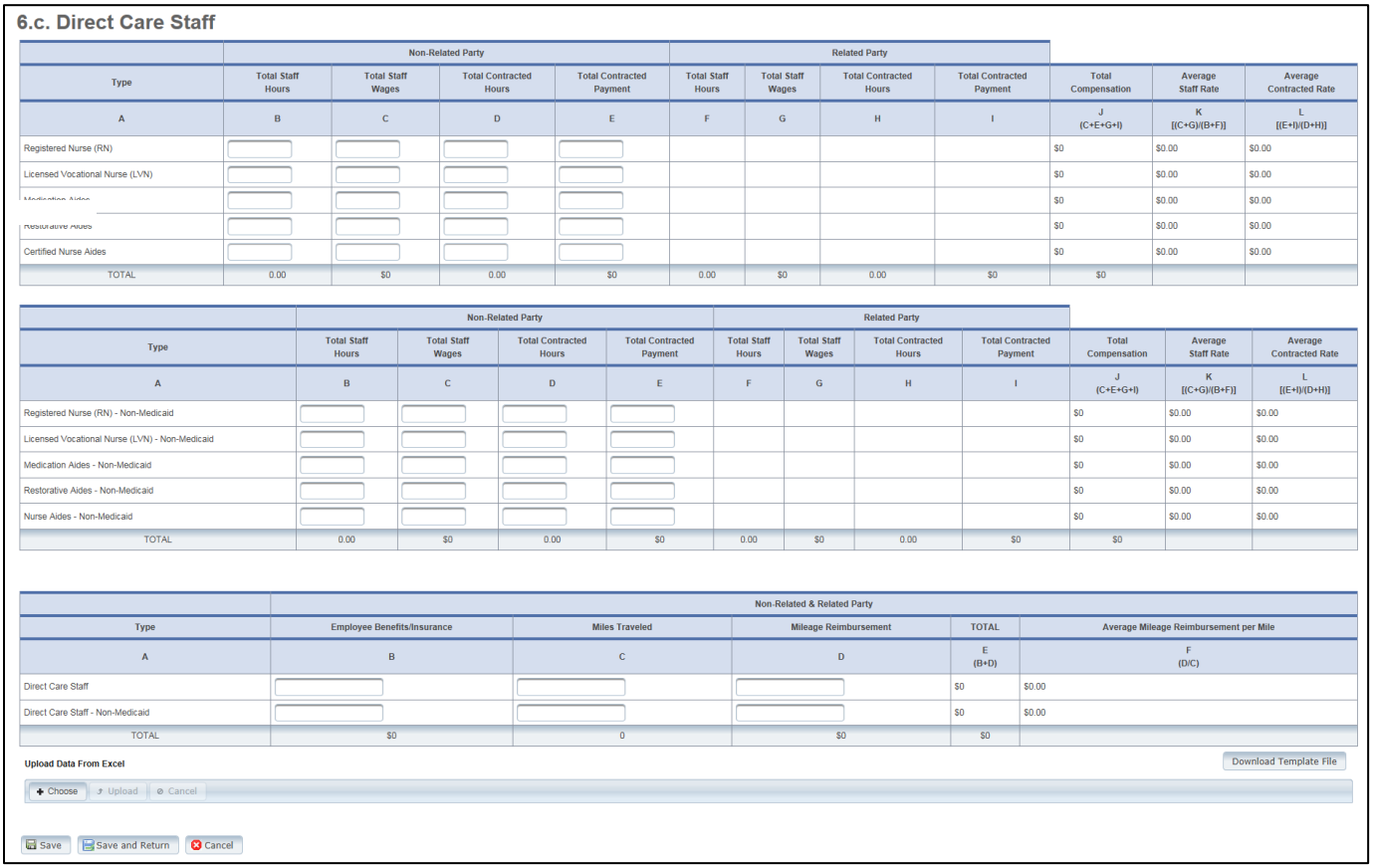
components will require a business component allocation method to be chosen and an allocation summary uploaded.

Step 6.c. Direct Care Staff

Report Direct Care Expenses in Step 6.c.

Purpose

To collect direct care staff hours, wages, benefits, and mileage reimbursement. This information is used for calculating staffing and spending recoupments.



6.c. Direct Care Staff

Type	Non-Related Party				Related Party						
	Total Staff Hours	Total Staff Wages	Total Contracted Hours	Total Contracted Payment	Total Staff Hours	Total Staff Wages	Total Contracted Hours	Total Contracted Payment	Total Compensation	Average Staff Rate	Average Contracted Rate
A	B	C	D	E	F	G	H	I	J (C+E+G+I)	K [(C+G)/(B+F)]	L [(E+I)/(D+H)]
Registered Nurse (RN)									$0	$0.00	$0.00
Licensed Vocational Nurse (LVN)									$0	$0.00	$0.00
Medication Aides									$0	$0.00	$0.00
Restorative Aides									$0	$0.00	$0.00
Certified Nurse Aides									$0	$0.00	$0.00
TOTAL	0.00	$0	0.00	$0	0.00	$0	0.00	$0	$0		

Type	Non-Related Party				Related Party						
	Total Staff Hours	Total Staff Wages	Total Contracted Hours	Total Contracted Payment	Total Staff Hours	Total Staff Wages	Total Contracted Hours	Total Contracted Payment	Total Compensation	Average Staff Rate	Average Contracted Rate
A	B	C	D	E	F	G	H	I	J (C+E+G+I)	K [(C+G)/(B+F)]	L [(E+I)/(D+H)]
Registered Nurse (RN) - Non-Medicaid									$0	$0.00	$0.00
Licensed Vocational Nurse (LVN) - Non-Medicaid									$0	$0.00	$0.00
Medication Aides - Non-Medicaid									$0	$0.00	$0.00
Restorative Aides - Non-Medicaid									$0	$0.00	$0.00
Nurse Aides - Non-Medicaid									$0	$0.00	$0.00
TOTAL	0.00	$0	0.00	$0	0.00	$0	0.00	$0	$0		

Type	Non-Related & Related Party				
	Employee Benefits/Insurance	Miles Traveled	Mileage Reimbursement	TOTAL	Average Mileage Reimbursement per Mile
A	B	C	D	E (B+D)	F (D/C)
Direct Care Staff				$0	$0.00
Direct Care Staff - Non-Medicaid				$0	$0.00
TOTAL	$0	0	$0	$0	

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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 direct care staff must be entered through **Step 6.b.** above. For each staff service type, enter hours, wages, and contract compensation for non-related party employees and contract staff who meet the definition of direct care. See **Definitions**, *Direct Care*. Only employees and contracted staff who meet the definition of direct care 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 direct care staff were compensated during the reporting pPeriod. This would include hours for both times worked and paid time off (sick leave, vacation, etc.).

Note: 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 with 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 explain and should reference the PRF or PPP offset.

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

Column J: Total Compensation: This column sums the wages for BOTH related and non-related party employee direct care staff.
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.

Benefits:

For all direct care staff, including the following benefits in the bottom table "Employee Benefits / Insurance." These benefits, except for 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 reported as salaries and wages, either the same or another year. See 1 TAC Section 355.103(b)(1)(A)(iii)(III)(-c-).

Note: **Costs that are not employee benefits** Per 1 TAC Section 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 cost 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 Section 355.103(b)(1)(A)(iii)(III)(-e-) and instructions on staff personal vehicle mileage reimbursement 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 direct care staff. For all direct care staff, including the personal vehicle miles traveled and the mileage reimbursement paid for allowable travel and transportation in the staff person's personal vehicle. Allowable travel and transportation include mileage and reimbursements of 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, which should be included as salaries and wages of the appropriate staff. Allowable travel and transportation also include 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:

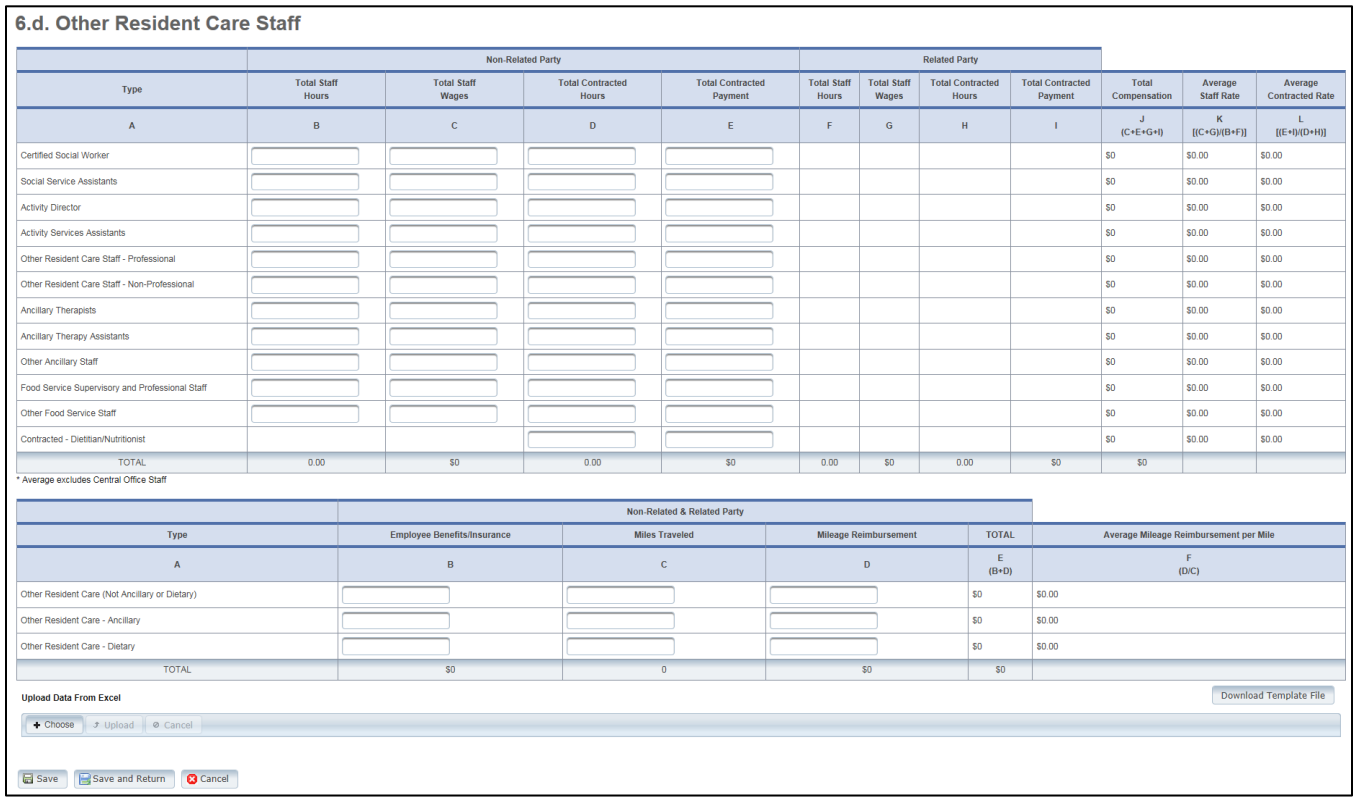
- 1/1/21 – 12/31/21 56.0 cents per mile
- 1/1/22 – 12/31/22 58.5 cents per mile

Column F 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 6.d. Other Resident Care Staff

Purpose

To collect other resident care staff hours, wages, benefits and mileage reimbursement.



6.d. Other Resident Care Staff

	Non-Related Party				Related Party						
Type	Total Staff Hours	Total Staff Wages	Total Contracted Hours	Total Contracted Payment	Total Staff Hours	Total Staff Wages	Total Contracted Hours	Total Contracted Payment	Total Compensation	Average Staff Rate	Average Contracted Rate
A	B	C	D	E	F	G	H	I	J (C+E+G+I)	K [(C+G)/(B+F)]	L [(E+I)/(D+H)]
Certified Social Worker									$0	$0.00	$0.00
Social Service Assistants									$0	$0.00	$0.00
Activity Director									$0	$0.00	$0.00
Activity Services Assistants									$0	$0.00	$0.00
Other Resident Care Staff - Professional									$0	$0.00	$0.00
Other Resident Care Staff - Non-Professional									$0	$0.00	$0.00
Ancillary Therapists									$0	$0.00	$0.00
Ancillary Therapy Assistants									$0	$0.00	$0.00
Other Ancillary Staff									$0	$0.00	$0.00
Food Service Supervisory and Professional Staff									$0	$0.00	$0.00
Other Food Service Staff									$0	$0.00	$0.00
Contracted - Dietitian/Nutritionist									$0	$0.00	$0.00
TOTAL	0.00	$0	0.00	$0	0.00	$0	0.00	$0	$0		

* Average excludes Central Office Staff

	Non-Related & Related Party				
Type	Employee Benefits/Insurance	Miles Traveled	Mileage Reimbursement	TOTAL	Average Mileage Reimbursement per Mile
A	B	C	D	E (B+D)	F (D/C)
Other Resident Care (Not Ancillary or Dietary)				$0	$0.00
Other Resident Care - Ancillary				$0	$0.00
Other Resident Care - Dietary				$0	$0.00
TOTAL	$0	0	$0	$0	

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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 cost report. All related-party staff must be entered through **Step 6.b.** above. For each service type, enter hours, wages, and contract compensation for non-related party employees and contract staff. All staff reported here perform either non-attendant care or non-administrative, 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 an 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 cost report preparer CANNOT report the expense of the meals provided for this NF contract as a single line item entry on the cost report. Shared dietary/central kitchen expenses must be reported on the cost 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 a central kitchen provides the services, see ***Appendix C*** for details as to the 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 a related-party employee and/or contract staff as described above reported in **Step 6.b.**, these columns are automatically populated after all nonrelated-party costs in Columns B-E have been entered.

Column J: Total Compensation: This column sums the wages for BOTH related and non-related party employees and other resident care staff.

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.

Benefits:

For all other resident staff, including the following benefits in the bottom table "Employee Benefits / Insurance." These benefits, except 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 reported as salaries and wages, either the same or another year. 1 TAC Section 355.103(b)(1)(A)(iii)(III)(-c-).

Note: Costs that are not employee benefits Per 1 TAC Section 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 cost report line items unless they are subject to payroll taxes, in which case they are reported as salaries and wages. See 1 TAC Section 355.103(b)(1)(A)(iii)(III)(-e-) and instructions on staff personal vehicle mileage reimbursement for further direction on the correct reporting of these costs.

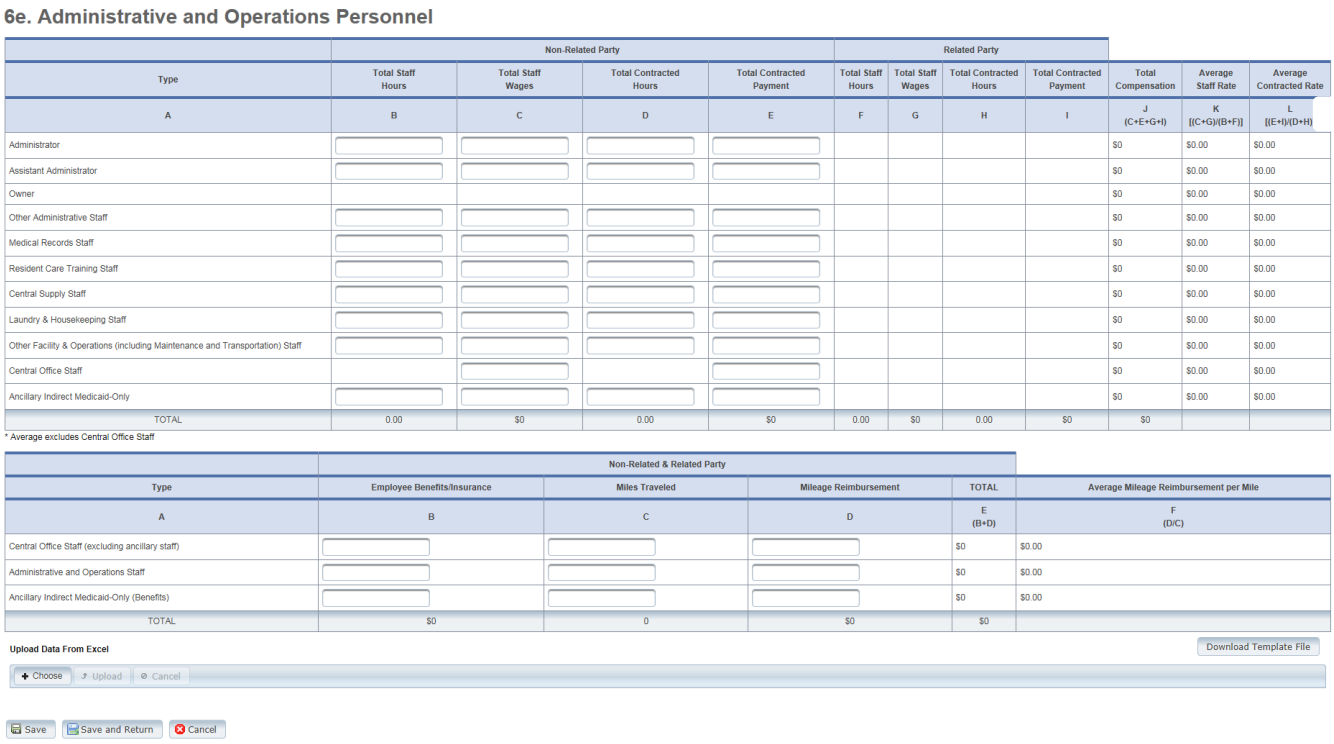
Miles Traveled and Mileage Reimbursement. These columns are for BOTH related and non-related party employees and other resident care staff. For all other resident care staff, including the personal vehicle miles traveled and the mileage reimbursement paid for allowable travel and transportation in the staff person’s personal vehicle. Allowable travel and transportation include mileage and reimbursements of 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 include mileage and reimbursements of other resident care staff for allowable training to which they traveled in their personal vehicle.

Step 6.e. Administrative and Operations Personnel (Cost Report only)

Note: this step is not applicable to Accountability Report.

Purpose

To collect administration and operations personnel hours, wages, benefits, and mileage reimbursement.



6e. Administrative and Operations Personnel

	Non-Related Party				Related Party						
Type	Total Staff Hours	Total Staff Wages	Total Contracted Hours	Total Contracted Payment	Total Staff Hours	Total Staff Wages	Total Contracted Hours	Total Contracted Payment	Total Compensation	Average Staff Rate	Average Contracted Rate
A	B	C	D	E	F	G	H	I	J (C+E+G+I)	K [(C+G)/(B+F)]	L [(E+I)/(D+H)]
Administrator									$0	$0.00	$0.00
Assistant Administrator									$0	$0.00	$0.00
Owner									$0	$0.00	$0.00
Other Administrative Staff									$0	$0.00	$0.00
Medical Records Staff									$0	$0.00	$0.00
Resident Care Training Staff									$0	$0.00	$0.00
Central Supply Staff									$0	$0.00	$0.00
Laundry & Housekeeping Staff									$0	$0.00	$0.00
Other Facility & Operations (including Maintenance and Transportation) Staff									$0	$0.00	$0.00
Central Office Staff									$0	$0.00	$0.00
Ancillary Indirect Medicaid-Only									$0	$0.00	$0.00
TOTAL	0.00	$0	0.00	$0	0.00	$0	0.00	$0	$0		

* Average excludes Central Office Staff

	Non-Related & Related Party				
Type	Employee Benefits/Insurance	Miles Traveled	Mileage Reimbursement	TOTAL	Average Mileage Reimbursement per Mile
A	B	C	D	E (B+D)	F (D/C)
Central Office Staff (excluding ancillary staff)				$0	$0.00
Administrative and Operations Staff				$0	$0.00
Ancillary Indirect Medicaid-Only (Benefits)				$0	$0.00
TOTAL	$0	0	$0	$0	

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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**. All related-party staff must be entered through **Step 6.b.** above. For each staff type, enter hours, wages, and contract compensation for non-related party employees and contract staff. All staff reported here perform administrative or operations 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 times worked and paid time off (sick leave, vacation, etc.).

For staff whose work hours are split between direct administrative and operational functions and other functions (e.g., part-time QIDP and part-time administrator), then in this Step, report only the hours and compensation directly associated with the provision of administrative and operations functions and supported by timesheets (e.g., the part-time administrator hours and compensation).

There should be no allocated costs reported in Administrator, Assistant Administrator, Owner, or Other Administrative Staff, with the exception of the Administrator/Director, whose costs must be reported in the designated line whether they are directly charged or allocated.

- **Administrator** – All NFs are expected to have an Administrator. The minimum time expected to be reported is 520 hours per year. If the Administrator is not compensated for time worked or does not provide the expected hours of service, then an explanation will be required.
- **Assistant Administrator** – Enter hours and compensation for the assistant administrator if such staff is contracted or employed by the provider.
- **Owner** – Enter here only if an Owner, Partner, or Stockholder is employed in an administration position other than Facility Administrator, Assistant Administrator, or central office employee.
- **Other Administrative Staff** – Enter here any other professional and nonprofessional administrative personnel such as Financial, Clerical, Human Resources, etc. staff.
- **Medical Records Staff -** Enter here the hours and compensation for employees who maintain and retrieve patient files and charts.
- **Resident Care Training Staff -** Enter here hours and compensation for employees who provide training to direct care staff and resident care staff other than direct care staff. Hours worked, salaries, wages, and taxable benefits earned by the staff being trained are to be reported in the appropriate resident care staff salaries/wages items and are not reported as Resident Care Training Staff in **Step 6.e**. Also, do not include the training staff salaries, wages, and taxable benefits for training administrative, maintenance, and other non-resident care staff.
- **Central Supply Staff -** Enter here hours and compensation for Central Office employees who order, stock, and maintain supplies.
- **Laundry & Housekeeping Staff -** Enter hours and compensation for employees who clean laundry and maintain the facility's cleanliness.
- **Other Facility & Operations (including Maintenance and Transportation) –** Enter here the hours and compensation for maintenance staff, transportation staff who were NOT reported as Direct Care Staff, and any other staff not otherwise captured as Direct Care Staff, Non-Direct Care Staff, Program Administration, or Central Office staff.
- **Central Office Staff –** Enter here the allocated portion of shared administrative staff. If the Administrator has been allocated to the cost report from the central office, assure that the portion of costs reported as Administrator above is not also reported in this line item.

- **Ancillary Indirect Medicaid-Only -** See 1 TAC Sections 355.103(b) and 355.105(b)(3). Enter here the allocated amount of central office salaries, wages, payroll taxes, and taxable employee benefits. See Schedule G and its instructions for guidelines regarding the transferring of salaries/wages, payroll taxes and workers' compensation costs, and employee benefits/insurance related to ancillary indirect Medicaid-Only central office staff. Providers are to report allocated salaries for central office staff in full, meaning that salary caps are not to be applied. If a central office employee also functions as a facility employee, the portion of time spent as a facility employee must be documented so that costs related to that portion of the employee's duties can be directly charged to the non-central office portion of the cost report.

Columns F-I: Related-Party Total Staff Hours, Total Staff Wages, Total Contract Hours, and Total Contract Payment: If there are a related-party employee and/or contract staff as described above reported in **Step 6.b.**, 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 the Total *Administrative and Operations Personnel* Compensation for that 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.

For the lower section:

For the second table in Step 6e, the Benefits/Insurance and Miles Traveled for Administrator, Assistant Administrator, Owner, Other Administrative Staff, Medical Records Staff, Resident Care Training Staff, Central Supply Staff, Laundry & Housekeeping Staff, and Other Facility & Operations Staff benefits should be reported as Administration and Operations Staff and Resident Care Staff.

Benefits/Insurance and Miles Traveled for Central Office Staff should be the only values reported as Central Office Staff, and Benefits/Insurance and Miles Traveled for Ancillary Indirect Medicaid-Only should be the only values to be reported as Ancillary Indirect Medicaid-Only.

Column B: Employee Benefits/Insurance: This column is for BOTH related and non-related party employee staff. For all staff reported in **Step 6.e.**, include the following benefits in this column. These benefits, except for paid claims where the employer is self-insured, must be directly 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 reported as salaries and wages, either the same or another year. See 1 TAC Section 355.103(b)(1)(A)(iii)(III)(-c-).

Note: Costs that are not employee benefits Per 1 TAC Section 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 cost report line items unless they are subject to payroll taxes, in which case they are reported as salaries and wages. See 1 TAC Section 355.103(b)(1)(A)(iii)(III)(-e-) and instructions on staff personal vehicle mileage reimbursement for further direction on the correct reporting of these costs.

Columns C and D: Miles Traveled and Mile

Mileage Reimbursement: These columns are for BOTH related and non-related party employee staff. For all staff reported in **Step 6.e.**, include the personal vehicle miles traveled and the mileage reimbursement paid for allowable travel and transportation in the staff person’s personal vehicle. Allowable travel and transportation include mileage and reimbursements of these 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. It also includes mileage and reimbursements of these staff for allowable training to which they traveled in their personal vehicle.

The maximum allowable mileage reimbursement is as follows:

- 1/1/21 – 12/31/21 56.0 cents per mile
- 1/1/22 – 12/31/22 58.5 cents per mile

Column E: Total of Benefits and Mileage Reimbursement: This column is the sum of Columns B + D.

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

Purpose

The purpose of Step 7 is to collect wages, compensation and benefits information for the contracted provider's Direct Cares staff, non-Direct Care staff, and administrative and central office staff.

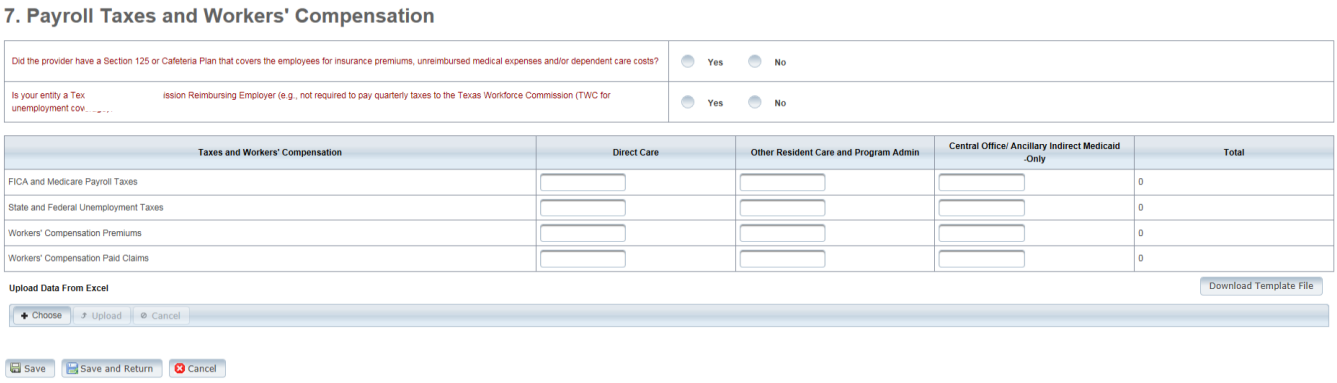
How do we use this information?

HHSC PFD uses this information to determine the contracted provider's employee and contracted staff expenses. Staff expenses are used in the report reconciliation process to determine spending compliance in the Direct Care Staff Compensation Rate Enhancement program and rate-setting calculations.

How to complete Step 7

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

If payroll taxes (i.e., Federal Insurance Contributions Act (FICA), Medicare, and state/federal unemployment) are allocated based on a percentage of salaries, the provider must disclose this functional allocation method. The use of a 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." If "Yes" is clicked, the provider must upload supporting documentation or select a file from the drop-down menu of documents that have already been uploaded.

Is your entity a Texas Workforce Commission Reimbursing Employer?

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

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

FICA & Medicare Payroll Taxes

Report the actual 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 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 should be 7.65% or less, and variations could occur due to PPP offsets and other items.

State and Federal Unemployment Taxes

Report both federal (Federal Unemployment Tax Act or FUTA) and state (Texas Unemployment Compensation Tax Act or SUTA) unemployment expenses.

Workers' Compensation Premiums

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

If the facility 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). According to the Texas Department of Insurance, a general liability insurance policy specifically excludes payment for an employee's on-the-job injuries; therefore, general liability premium costs must not be reported on this item.

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

Workers’ Compensation Paid Claims

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

However, only the amount for any claims paid should be reported on the cost report, not the amount contributed to any (reserve account. There is a cost ceiling to be applied to allowable self-insurance workers' compensation costs or costs where the provider does not provide total coverage, and that ceiling may limit the costs which may be reported. See 1 TAC Sections 355.103(b)(13)(B) and 355.105(b)(2)(B)(ix) and ***Appendix E.***

Step 8. Facility and Operations Costs

NOTE: this step does not apply to the Accountability Report.

Purrpose

The purpose of Step 8 is to collect expense information for the contracted provider and use it directly or indirectly in the provision of contracted services.

How do we use this information?

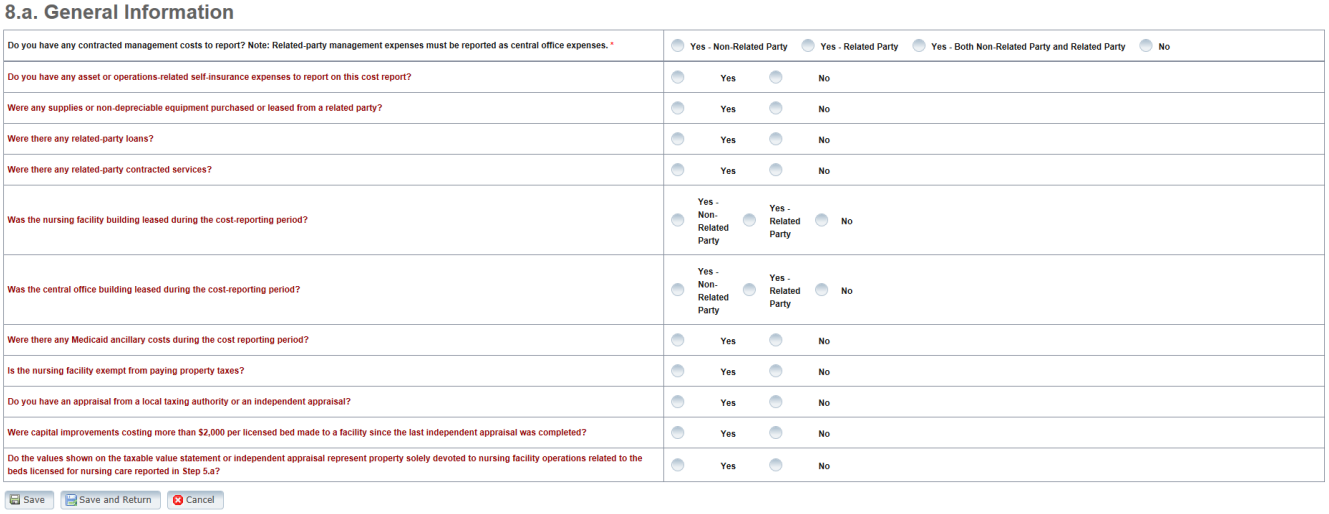
HHSC PFD uses this information for rate-setting calculations and legislative cost analysis.

How to complete Step 8

Step 8.a. General Information

Purpose

To collect Facility and Operations costs. This information will lock or unlock certain sections in Step 8.



8.a. General Information

Do you have any contracted management costs to report? Note: Related-party management expenses must be reported as central office expenses. *	Yes - Non-Related Party Yes - Related Party Yes - Both Non-Related Party and Related Party No
Do you have any asset or operations-related self-insurance expenses to report on this cost report?	Yes No
Were any supplies or non-depreciable equipment purchased or leased from a related party?	Yes No
Were there any related-party loans?	Yes No
Were there any related-party contracted services?	Yes No
Was the nursing facility building leased during the cost-reporting period?	Yes - Non-Related Party Yes - Related Party No
Was the central office building leased during the cost-reporting period?	Yes - Non-Related Party Yes - Related Party No
Were there any Medicaid ancillary costs during the cost reporting period?	Yes No
Is the nursing facility exempt from paying property taxes?	Yes No
Do you have an appraisal from a local taxing authority or an independent appraisal?	Yes No
Were capital improvements costing more than $2,000 per licensed bed made to a facility since the last independent appraisal was completed?	Yes No
Do the values shown on the taxable value statement or independent appraisal represent property solely devoted to nursing facility operations related to the beds licensed for nursing care reported in Step 5.a?	Yes No

Save Save and Return Cancel

Do you have any contracted management costs to report? Note: Related-party management expenses must be reported as central office expenses.

If "Yes," please select "Yes - Non-related Party," "Yes - Related Party," or "Yes - Both Non-Related Party and Related Party," or "No."

Do you have any asset or operations-related self-insurance expenses to report on this Cost Report?

If "Yes", please select "Yes" or "No" for all of the following self-insurance expenses.

Click either “Yes” or “No” for each expense type. Those self-insuring for vehicle expenses must upload a copy of the Texas Department of Public Safety (TDPS) Certificate of Self-Insurance. See **Appendix E.**

Were any supplies or non-depreciable equipment purchased or leased from a related party?

Click either “Yes” or “No.” If “Yes,” **Step 8.b.** will become available for entry of related-party transactions. Refer to **Definitions**, *Related Party,* and *Related-Party Transactions*.

Were there any related-party loans?

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

Were there any related-party contracted services?

Answer "Yes" if a related organization provided any contracted or consultant services (including contracted management). **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 cost 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 cost report period, you would 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 cost report does not exempt a facility from the requirement to submit another copy with the current Schedules and attachments to the cost report.

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

Indicate whether or not the central office building was leased during all or part of the cost-reporting period. If the facility was leased during any part of the cost report period, you will need to upload a Copy of the Lease Agreement and HHSC Schedule D2 or other similar documentation. No copy of the central office-building lease is required if the lease is with an unrelated party. Submission of the central office building lease agreement with a prior year's cost report does not exempt a facility from the requirement to submit another copy with the current Schedules and attachments to the cost report.

Were there any Medicaid ancillary costs during the cost reporting period?

Indicate whether or not there were any Medicaid ancillary costs during the cost reporting period. If "Yes," complete and upload Schedule G and transfer the amounts in Column G to the Cost Report Step indicated on the schedule. 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 the costs incurred for providing ancillary services to Medicaid-Only residents.

Is the nursing facility exempt from paying property taxes?

Indicate whether or not the facility is exempt from paying property taxes.

Do you have an appraisal from a local taxing authority or an independent appraisal?

Indicate "Yes" if you have either an appraisal from a local taxing authority or an independent appraisal. If you indicate "Yes," you will need to upload a copy of the appraisal. Also, if you answer "Yes," you will need to indicate the type of appraisal (in the drop-down menu, select Independent or Local Taxing Authority), the Year of valuation for appraised values reported, the Appraised Value of Buildings and Other Improvements (excluding personal property), and the Appraised Value of Land. Only the value property solely devoted to nursing facility operations should be reported here. Do not include appraisals for land that the nursing facility does not use. Do not include appraisals for equipment, inventory, or personal property.

Were capital improvements costing more than $2,000 per licensed bed made to a facility since the last independent appraisal was completed?

Indicate whether or not any capital improvements costing more than $2,000 per licensed bed have been made to the facility since the last independent appraisal was completed. This is only necessary if you have an independent appraisal.

Do the values shown on the taxable value statement or independent appraisal represent property solely devoted to nursing facility operations related to the beds licensed for nursing care reported in Step 5a?

Indicate whether or not the values shown on the taxable value statement or independent appraisal represent property solely devoted to nursing facility operations related to the beds licensed for nursing care reported in **Step 5.a.**

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

Purpose

These sections report Related Party Non-Depreciable Equipment and Supplies, Loans, and Contracted Services.

See 1 TAC Section 355.102(i) for specific details and requirements on related-party transactions. If the responses to the final three questions in **Step 8.a.** above were all "No," then **Steps 8.b.-8.d.** will be disabled, and the preparer will not be able to make entries. If any of those questions 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 contains 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 furnishing 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 Section 355.102(i)(5)) is provided to the general rule applicable to related organizations if the contracted provider demonstrates for each cost 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 PFD no later than 45 days before the due date of the cost report to be considered for that year's cost report. The provider's request for an exception must demonstrate that all of the following criteria have been met:

1. The supplying organization is a bona fide separate organization. See 1 TAC Section 355.102(i)(5)(A).
2. 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 Section 355.102(i)(5)(B).
3. There is an open, competitive market for the type of services, equipment, facilities, leases, or supplies furnished by the related organization. See 1 TAC Section 355.102(i)(5)(B).
4. The services, equipment, facilities, or supplies are those which are commonly 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 Section 355.102(i)(5)(C).
5. 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 Section 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 cost 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 cost report. If the exception granted by Medicare is no longer applicable due to changes in the 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 Section 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 cost report, HHSC PFD is not required to process the request for that cost-reporting year.

Step 8.b Related-Party Non-depreciable Equipment and Supplies

This Step should include all purchases and leases from a related individual or organization of equipment and/or supplies with a value of less than $5,000 and/or a useful life of less than one year.

1. Click "Add record."

All columns must be completed for each related-party transaction.

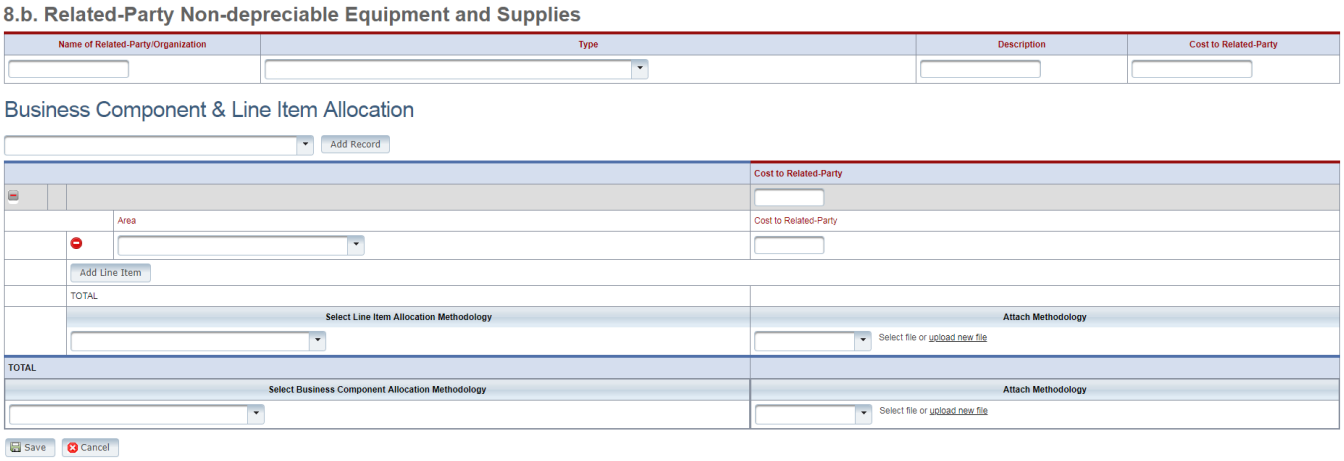
A. Name of Related-Party/Organization – Enter the name of the related party or organization from whom the contracted provider purchased or leased equipment and/or supplies. If the contracted provider is a proprietorship, the related organization could be the individual owner rather than a separate corporation.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

B. Type – must be chosen from the drop-down menu. This is the cost report line item on which the allowable expense will be reported.

C. Description – Describe the items/goods purchased or leased from the related party. Examples include office supplies, letterhead, leased or purchased copiers or computers (below the depreciable value), etc. The entry of related-party lending/loans contracted services, and depreciable purchases or leases will be discussed in the other Steps below.

D. Cost to Related Party – This amount should be the actual cost to the related individual or organization, not to exceed the price of comparable non-depreciable equipment and/or supplies that could be purchased or leased elsewhere in an arm's-length transaction.

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

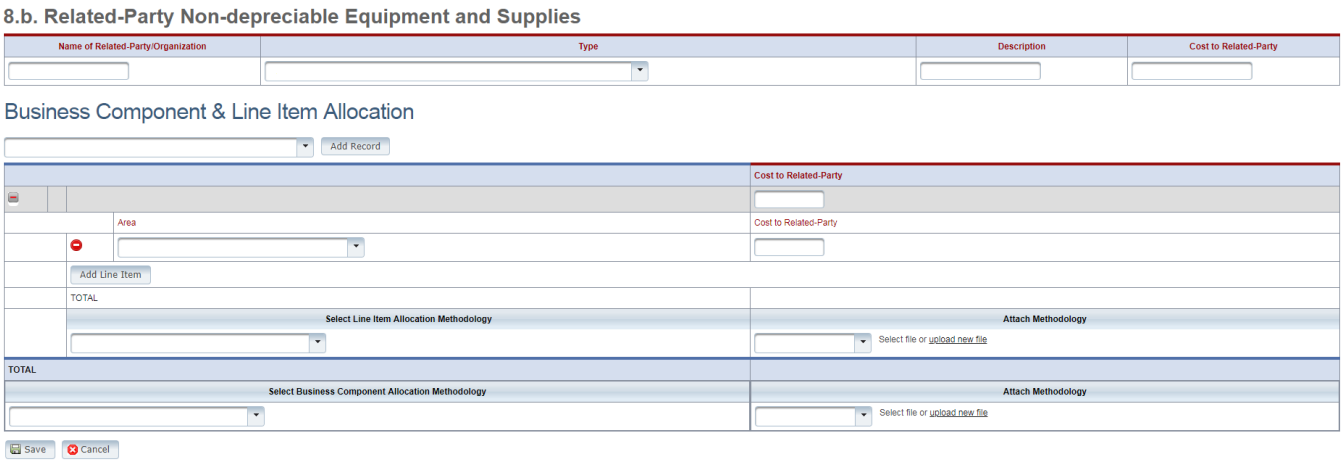


The available business components are limited to the businesses and contracts entered in **Step 3**. If a business component that should receive a portion of the allocated cost of the item(s) is not in the drop-down menu, then the preparer should return to **Step 3.b.** and enter the missing business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

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

3. Enter all Cost Area Information



A. Cost to Related Party – On the grey bar, enter the cost allocated or direct cost to each business component.

B. Area – The dropdown menu for "Area" includes all cost areas reportable in this cost 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. Cost to Related Party – Enter the cost to the related party direct cost or allocate to this cost area within the business component.

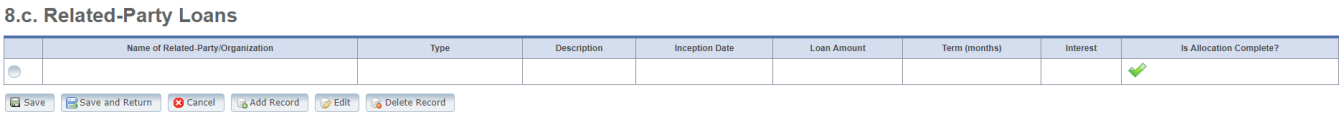
D. Cost Area Allocation Methodology – If allocated to multiple cost areas, an allocation method must be chosen and an allocation summary uploaded. This will be required only if there are multiple cost areas selected.

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.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 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 quickest source of prime interest rate information for those with Internet access 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.

1. Click "Add record."



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 provider 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 cost report.

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

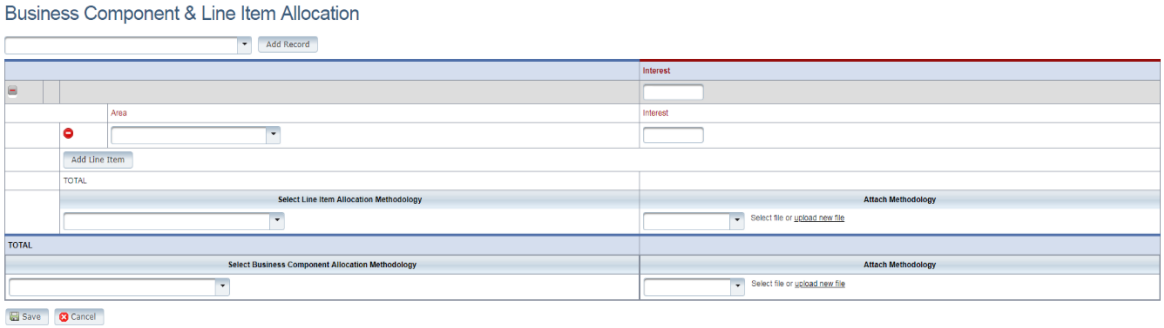
D. Inception Date – Month and year the loan was effective.

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.

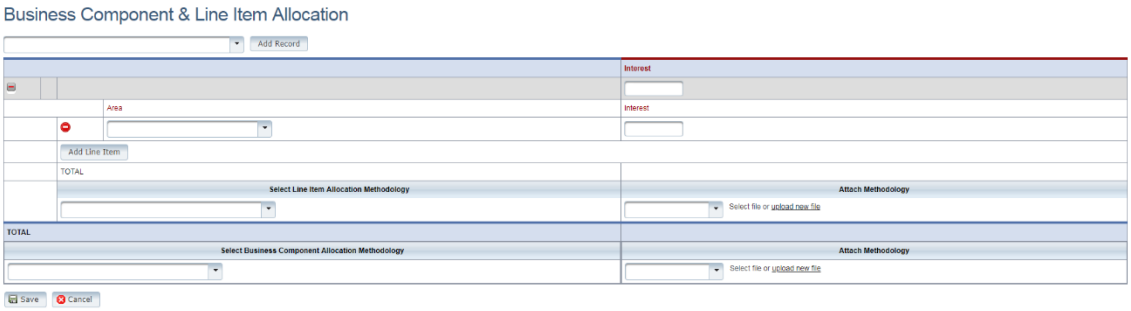
2. Click "Save" to enter Business Component and Cost Area Allocation(s)



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

3. 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 cost 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 that 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 are multiple cost areas selected.

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

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

Step 8.d. Related-Party Contracted Services

Report in this Step the purchase of services, such as accounting, legal, and consulting services, from a related-party organization or an individual who is NOT an employee of the contracted provider. If the related individual IS AN EMPLOYEE of the contracted provider, a controlling entity, or other related entity, do not complete this Step, but rather complete **Step 6.b**. If reporting a related individual who is providing, as contract labor, activities that are typically performed by employee staff (e.g., Direct Care and Non-Direct Care staff services, Program Administration staff services, etc.),
complete **Step 6.b**.

Note: Step 8.d. is just for related party consultants and accountants (etc.) but not management. Contracted Management should be entered in **Step 8.f.**

1. Click "Add record"

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 provider purchased services as described above. 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.

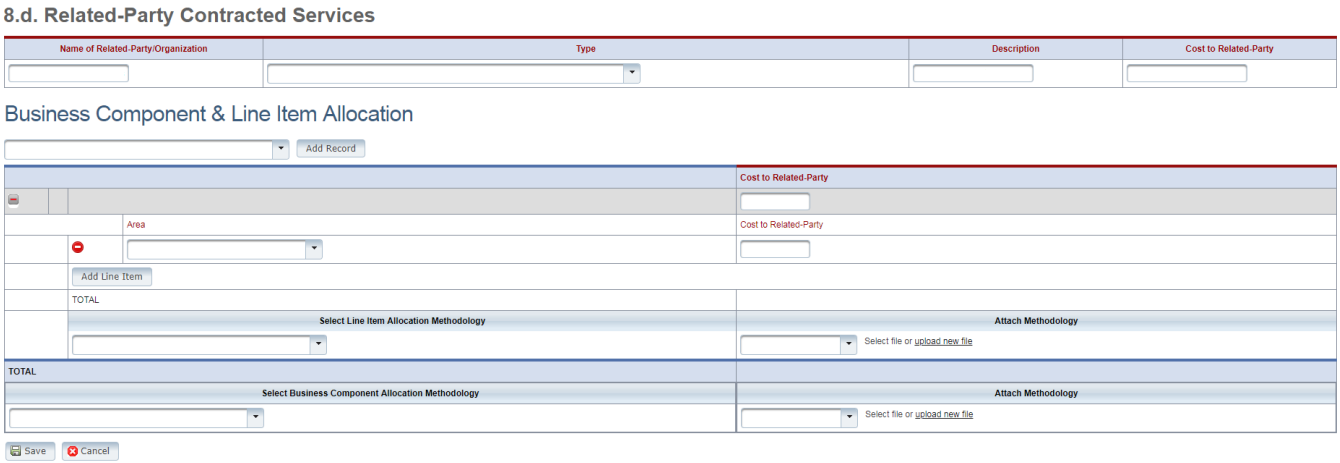
B. Type – must be chosen from the drop-down menu. This is the line item on which the allowable cost will appear in the cost report.

C. Description – Describe the services purchased from the related-party organization or individual. Examples may include data processing services, legal services, accounting services, management consulting services, medical director, accountant, building maintenance, and lawn maintenance.

D. Cost to Related Party – This amount should be the actual cost to the related individual or organization providing the services, not to exceed the price of comparable services that could be purchased elsewhere in an arm's-length transaction.

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

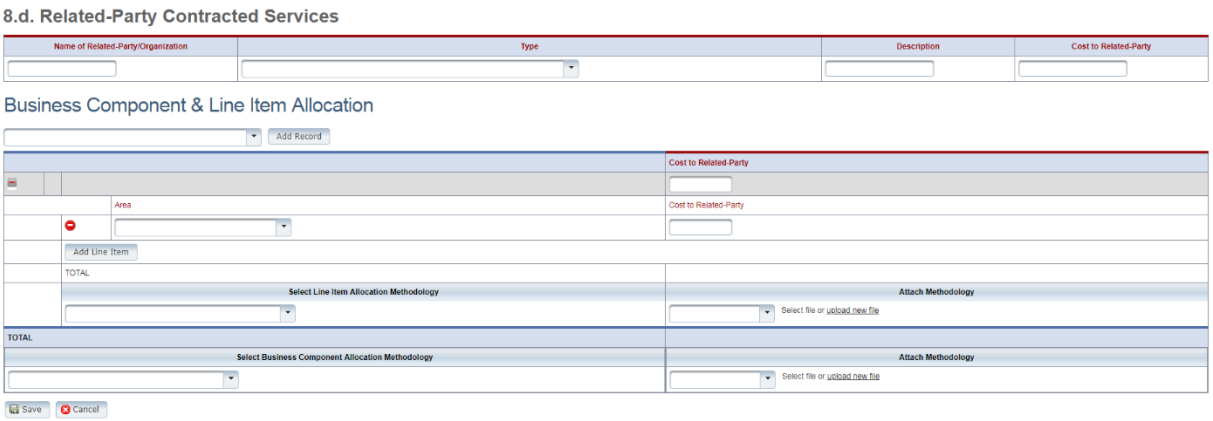
The available business components are limited to the businesses and contracts entered in **Step 3**. If a business component that should receive a portion of the allocated cost of the service(s) is not on the list, then the preparer should return to **Step 3.b.** and enter the missing business component data. Allocate or direct cost all costs reported for the Related Party/Organization under Cost to the Related Party 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 the provider entity only has one business component, the drop-down menu does not appear, and the single business component is automatically entered under the 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.

3. Enter All Cost Area Information



A. Cost to Related Party – On the grey bar, enter the cost allocated or direct costed to each business component.

B. Area – The dropdown menu for "Area" includes all cost areas reportable in this cost 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 that can be directly charged to the contracted provider should be reported as Program Administration. See Definitions, Central Office.

C. Cost to Related Party – Enter the cost to the related party 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 allocated to multiple business components will require a business component allocation method to be chosen and an allocation summary uploaded.

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

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 calculator and a non-depreciable bookshelf would be reported as Operations Supplies.

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

The asset type chosen in **Step 8.e.** will determine the line item on which the allowable cost will appear in the cost report. The various types of assets include:

A. Depreciation: Buildings and Building Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, Other Amortization

   i. ***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 expenses (incurred during the construction of the building, not mortgage interest) associated with a newly constructed or renovated building (including major additions). Buildings would 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.

ii. ***Building Fixed Equipment:*** any equipment attached to the building and 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.

iii. ***Leasehold Improvements:*** improvements a lessee makes to a leased building. These improvements are attached to the building or land permanently, and they become the lessor's property 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 is 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.

iv. ***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 expenses associated with newly constructed or renovated buildings. Providers who rent or lease the facility must report land improvement depreciation as leasehold improvement depreciation.

v. ***Research and Development (R&D), Organizational, and Start-up:*** must be amortized over 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 properly identified capitalizable construction costs must be appropriately classified as such and excluded from startup costs. *Costs related to care for individuals incurred after the first individual is admitted but before the provider is Medicaid-certified are unallowable.*

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 that 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.

NOTES

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

Minimum useful lives must be consistent with "Estimated Useful Lives of Depreciable Hospital Assets", published by the American Hospital Association (AHA) (2018 Version Item Number). Copies of this publication may be obtained by contacting:

Mail: AHA Services, Inc.; 155 N. Wacker Dr; Chicago, IL 60606

Toll Free: 800-424-4301

Website: AHA Online Store

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 cost 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)(7)(A-C).

Providers have an option of reporting in **Step 8.e.** each single capital asset and allowing the system to determine the straight-line depreciation amount applicable to the cost report or reporting the depreciation expense per category at the summary level by business component and line item. Providers must choose a depreciation method in **Step 2.** Once the cost report is certified, the provider cannot change the method of reporting depreciation. This method will carry from year to year. Note that any combined entity that includes a 24-Hour Residential Child Care contract will not be able to report capital assets on the summary level due to Title IV-E requirements. These providers must report all capital assets individually.

Reporting Capital Assets Individually:

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.***

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 cost 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 screens. Nonrelated-party leases are reported in **Step 8.f**.

C. Asset – This is the line item on which the allowable cost will appear in the cost report. If it is a related-party lease, a drop-down menu with additional expense types will be available to enter the related-party cost.

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

E. 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 HHSC PfD 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.

F. Asset in Service at the end of Period? – Click "Yes" or "No" to note whether this item was in service at the end of the cost 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.

G. Years of Useful Life – The 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. For Used Vehicles, determine the required useful life and enter that. Per 1 TAC Section 355.103(b)(7)(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.

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

I. 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 the historical cost for Medicaid cost-reporting purposes. No other salvage values are required.

J. Depreciation Basis – Calculated figure equal to H minus I.

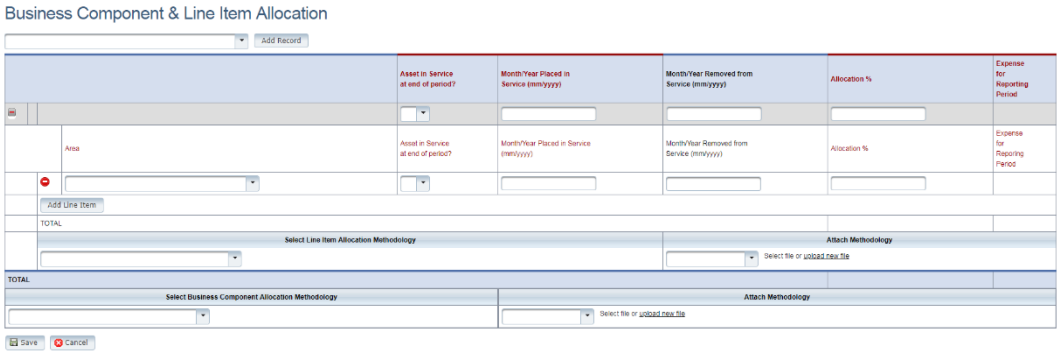
K. Prior Period Accumulated Depreciation – Calculated figure. Based on the date placed in service and calculation of depreciation on the Depreciation Basis from that date to the beginning date of the cost reporting period.

L. Depreciation for Reporting Period – Calculated figure. Based on the date placed in service, the beginning date of the cost reporting period, and any date entered as Month/Year removed from service) and the remaining useful life.

M. Total Expense for Reporting Period – Calculated figure. For Related-party leases, this will include costs from C. **d) – f)** above and 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 the provider entity only has one business component, the drop-down menu does not appear, and the single business component is automatically entered under the 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 the year. This question allows for flexibility in how asset allocation may change throughout the year.

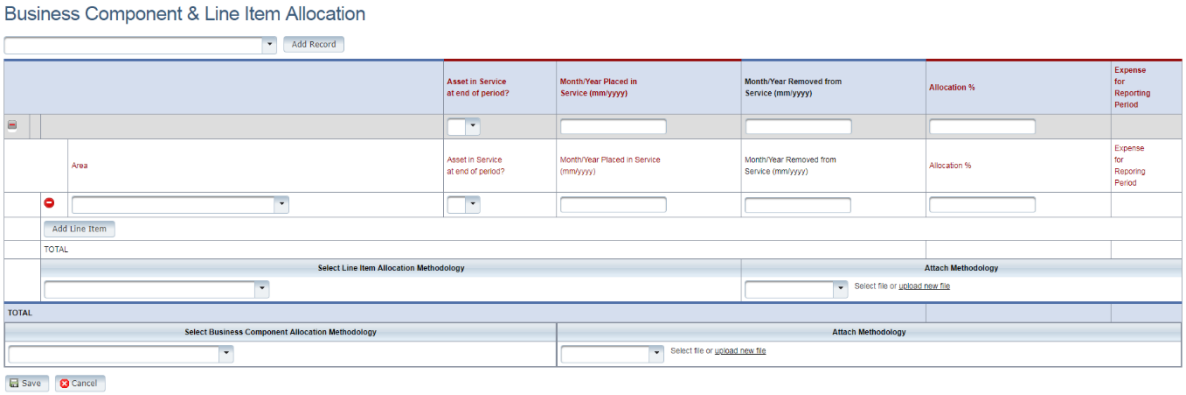
b) Month/Year Placed in Service (mm/yyyy) – Enter the month, and year the asset was initially placed in service for depreciation purposes for this specific business component.

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



Area – The dropdown menu for "Area" includes all cost areas reportable in this cost 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 that can be directly charged to the contracted provider should be reported as Program Administration. See Definitions, *Central Office*.

A. Asset in Service at the 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 asset to be taken out of service for a single cost area but not for all. The allocation of an asset may also change throughout the year. This question allows for flexibility in how asset allocation may change throughout the year.

B. 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.

C. 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.

D. Allocation Percentage – The percentage of costs allocated to this specific cost area.

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

F. 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.

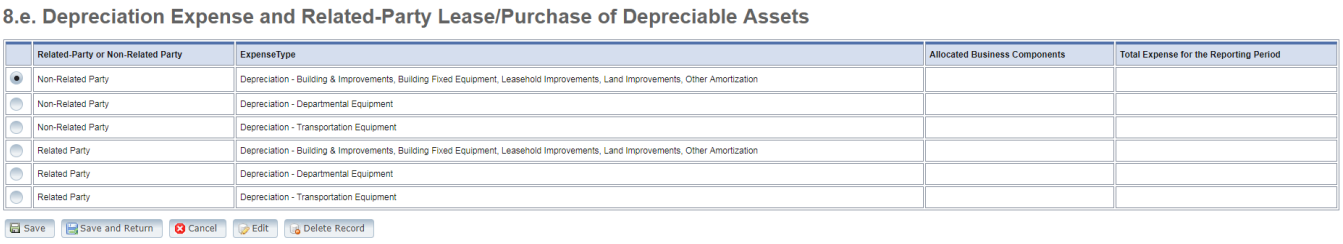
G. Business Component Allocation Methodology – After all business component cost area allocations have been completed, an expense allocated to multiple business components will also require a business component allocation method be chosen and an allocation summary uploaded.

<u>Capital Assets at the Summary Level:</u>

Calculate the depreciation for each capital asset outside of STAIRS. Use the appropriate minimum useful lives in the American Hospital Association's 2013 guide; an abbreviated list of some useful lives is included in ***Appendix D.*** Summarize the depreciation for the capital assets by asset category, which includes related party status and whether the asset is leased or owned. Once summarized, allocate the capital assets to each business component and cost report in the combined entity. Depreciation calculations and allocation summaries must be uploaded.

Providers will need to enter the summary data each year.

1. Select the asset type, then click "Edit" to enter Business Component Depreciation



2. Enter the total amount of depreciation for the asset type by business component and line item

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

Depreciation - Building & Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, Other Amortization

Business Component & Line Item Allocation

Type	Contracting Entity	Program Admin & Operation	Central Office
100006001 - NF	ZZZ RAD NF	0	0
100006002 - NF	ZZZ RAD NF	0	0
Total			

Depreciation - Building & Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, Other Amortization	
Type	Total By Cost Report
Depreciation - Building & Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, Other Amortization	
Total	0

Attach Supporting Documentation
--- Select file or upload new file

Save Cancel

A. Enter the dollar amount of the summarized depreciable asset allocated to each business component and each cost report in the applicable line item. Note that while all cost reports include Program Administration and Operations and Central Office line items, some cost reports have additional line items unique to that cost report. The expense will appear in the cost report on the appropriate line item.

B. After all business component and cost report summarized allocations have been completed, an expense that is allocated to multiple business components and/or cost reports will also require that depreciation calculations and allocation summaries be uploaded.

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

This screen consists of a column for the Line Item Names, three for Nonrelated-Party Cost Areas, and three for Related-Party Cost Areas, a column to total all expenses in each line item, and a column for notes. The three columns each for Nonrelated- and Related-Party Cost Areas correlate to the Program Administration & Operations and Central Office, plus a Total. Facility and Operations costs should be reported if the Provider has a Program Administration office. 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 contracted provider should be reported in the specific cost area as appropriate. The Program Administration & Operations columns are intended for reporting facility and operations costs that directly support the contracts included in the Cost Report Group for which the cost report is being prepared. The Central Office column is intended to capture the allocated portion of shared (i.e., central office) administrative costs. It is important to report all costs in the correct cost area.

The first column of this screen 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 cost 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 contracted provider itself. These are program administrative expenses and should be directly charged to the contracted provider. There should be no allocated costs reported in the program administration cost area, except for an administrator 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 the contracts included in the Cost Report Group, 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 the organization (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 cost report for the contracted provider, 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 contracts include in the Cost Report Group must be reported in the Central Office cost area.

- Allowable central office costs include those necessary for providing 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 cost 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 cost report.
- For details on allocating shared costs, see ***Appendix B.***


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

	Non-Related Party			Related Party				
Type	Program Admin & Operation	Central Office	Non-Related-Party Total	Program Admin& Operation	Central Office	Related-Party Total	TOTAL	Notes (optional)
Rent / Lease - Building and Building Equipment								
Rent / Lease - Departmental Equipment / Other								
Interest - Mortgage								
Insurance - Building and Equipment								
Taxes - Ad Valorem Real Estate								
Utilities & Telecommunications								
Building / Equipment - Contracted Services and Maintenance and Repairs								

	Non-Related Party			Related Party				
Type	Program Admin & Operation	Central Office	Non-Related-Party Total	Program Admin& Operation	Central Office	Related-Party Total	TOTAL	Notes (optional)
Depreciation - Building & Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, Other Amortization								
Depreciation - Departmental Equipment								
Other Non-Depreciable Equipment and Operations Supplies								
Depreciation - Transportation Equipment								
Rent / Lease - Transportation Equipment or Contracted Transportation Services								
Transportation - Maintenance, Repairs, Gas, Oil, Interest, Insurance, Taxes, Other								
Staff Training / Seminars - Non Admin Staff								
Staff Training / Seminars - Admin								

	Non-Related Party			Related Party				
Type	Program Admin & Operation	Central Office	Non-Related-Party Total	Program Admin& Operation	Central Office	Related-Party Total	TOTAL	Notes (optional)
Insurance - Liability								
Travel (not to include mileage reimbursement)								
Fees - Management Contract								
Fees - Contracted Administrative, Professional, Consulting and Training Services								
Licenses and Permits								
Interest - Other								
Taxes - Texas Corporate Franchise Tax								

	Non-Related Party			Related Party				
Type	Program Admin & Operation	Central Office	Non-Related-Party Total	Program Admin& Operation	Central Office	Related-Party Total	TOTAL	Notes (optional)
Taxes - Other (describe)								
Advertising								
Dues and Memberships								
Other (describe)								

	Non-Related Party			Related Party				
Resident Care	Program Admin & Operation	Central Office	Non-Related-Party Total	Program Admin& Operation	Central Office	Related-Party Total	TOTAL	Notes (optional)
Consultants								
Contracted Services								
Supplies								
Off-site Training/Seminars & Travel - Resident Care Staff								
Bio-Hazard Waste Disposal								
Other Resident Care Expenses								

	Non-Related Party			Related Party				
Resident Care: Ancillary Services - Medicaid - Only Residents	Program Admin & Operation	Central Office	Non-Related-Party Total	Program Admin& Operation	Central Office	Related-Party Total	TOTAL	Notes (optional)
Therapy Supplies								
Consultants - Physical, Occupational & Speech Therapy								
Contract and Off-Site Therapy								
Supplies: Nutritional Therapy Supplies, Medical, Nursing & Incontinent								
Diagnostic Laboratory and Radiology								
Drugs and Pharmaceuticals								
Oxygen								
DME Purchased by Provider								
DME Rental/Lease Expense								

	Non-Related Party			Related Party				
Dietary	Program Admin & Operation	Central Office	Non-Related-Party Total	Program Admin& Operation	Central Office	Related-Party Total	TOTAL	Notes (optional)
Contract Dietary Services								
Supplies/Other Dietary Costs								
TOTAL								

Upload Data From Excel — Download Template File

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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 screen.

1. Rent/Lease – Building and Building Equipment

A. Report 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 the deposit not refunded and used for allowable costs is allowable for cost-reporting purposes at that time. Lease deposits made for remodeling and the 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 the 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 payments made for goodwill (see Definitions, Goodwill) are not allowable costs.

2. Rent/Lease – Departmental Equipment/Other – Report departmental equipment's lease/rental costs. Departmental equipment includes telephone systems, pagers, facsimile (FAX) machines, photocopiers, and computers.

    A. Do not enter directly here if the rental/lease is from a related party. The lease and related costs must be entered either in **Step 8.b**. if the departmental 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 departmental equipment is depreciable (items with a cost of $5,000 or more and a useful life of more than one year).

3. Interest – Mortgage – See 1 TAC Section 355.103(b)(11). Reasonable and necessary interest on current and capital indebtedness is an allowable cost.

A. Report the interest expense accrued during the reporting period 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 loan, 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, and 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.

4. Insurance – Building and Equipment

A. Costs for insurance premiums for buildings, contents, and grounds must be reported with amounts accrued for premiums, modifiers, and surcharges and net of any refunds and discounts actually received or settlements paid during the same cost-reporting period (i.e., the premiums are accrued and related expenses are reported on a cash basis).

B. Self-insurance is a means whereby a contracted provider undertakes the risk to protect itself against anticipated liabilities by providing funds in an amount equivalent to liquidating those liabilities. Self-insurance can also be described as being uninsured. See 1 TAC Section 355.103(b)(13)(B) for additional requirements. Contributions to self-insurance funds or reserves that do not represent payments based on current liabilities are unallowable costs. The amount of allowable insurance costs may also be subject to a cost ceiling. See also 1 TAC Section 355.103(b)(13)(E) and ***Appendix E.***

5. Taxes – Ad Valorem Real Estate – See 1 TAC Section 355.103(b)(12). Report in this item the cost of ad valorem real estate taxes related to Program Administration and/or Central Office buildings. For the cost reporting period, tax expenses must be reported on an accrual basis only. If a tax statement covers any period of time outside the cost-reporting period, the cost must be prorated so that the amount reported on the cost report represents only the cost-reporting period.

    A. Texas corporate franchise taxes are reported in Taxes – Texas Corporate Franchise Tax below.

    B. Personal property taxes and other operational taxes are reported in Taxes – Other below.

6. Utilities & Telecommunications

    A. Biohazard Waste

    B. Electricity, Gas, Water, Wastewater, Garbage. See 1 TAC Section 355.103(b)(8). For utility costs to be allowable on the Cost Report, the utilities must be used directly or indirectly in the provision of contracted services. Report the costs associated with buildings in the appropriate area.

    C. Telecommunications utility costs associated with the contracts included in the Cost Report Group are reported here. Telecommunications refers to the cost for telephone, pager, and facsimile service only and not the cost of purchasing, leasing, or maintaining the associated equipment.

7. Building/Equipment – Contracted Services and Maintenance and Repairs

    A. Report expenses for contract services relating to building/grounds repairs and maintenance (including contracted janitorial services, contracted fire alarm inspections, and contracted lawn services) here. See 1 TAC Section 355.103(b)(10)(B).

    B. Report maintenance supplies related to facility maintenance and non-depreciable repairs and maintenance costs associated with buildings, building equipment, and grounds in this item. See 1 TAC Section 355.103(b)(9)(A-B).

    C. Maintenance and Repairs – Report the applicable amount of building and equipment maintenance and repair expenses related to the contracts to include in the Cost Report Group. Repairs and maintenance expenses are categorized as ordinary or extraordinary repairs for cost-reporting purposes.

        a. Ordinary repairs and maintenance are defined as outlays for parts, labor, and related supplies that are necessary to keep an asset in operating condition but neither add materially to the use value of the asset nor prolong its life appreciably. Ordinary repairs include, but are not limited to, painting, wallpapering, copy machine repair, or repairing an electrical circuit.

        b. Extraordinary or major repairs involve relatively large expenditures, are not normally recurring, and usually, increase the use value or the service life of an asset beyond what it was before the repair. Extraordinary repairs include, but are not limited to, major improvements in a building's electrical system, carpeting an entire building, replacement of a roof, or strengthening the foundation of a building. Extraordinary repairs that cost $2,500 or more and have a useful life in excess of one year may not be reported directly in this item. They must be capitalized and depreciated by reporting in **Step 8.e.**. See 1 TAC Section 355.103(b)(9)(A-B).

8. 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.

9. Depreciation – Departmental Equipment – Enter all departmental equipment 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.

10. Operations Supplies – for all cost items, report only net expenses, meaning gross expenses less purchase discounts, rebates, returns or allowances.

A. Hepatitis B vaccinations, TB tests, Chest X-rays, Drug Tests, and Physicals – Report under either Program Administration or Central Office (when a properly allocated cost of the Central Office) supplies used to administer Hepatitis B vaccinations to provider staff, as well as costs related to tuberculosis (TB) tests, chest x-rays, drug tests, and physicals.

B. Non-depreciable Equipment – Report items that cost less than $5,000 or have a useful life of less than one year as supplies. Report here such non-depreciable equipment used for services (i.e., nursing, medical records, staff training, and central supply), for program administration, and the allocated portion of central office supplies.

   a. Small equipment that costs $5,000 or more and has a useful life of more than one year is considered Departmental Equipment and should be entered as such in **Step 8.e.**

   b. Non-depreciable equipment purchased or leased from a related party may not be reported here directly. Enter in **Step 8.b.** and the allowable costs will be transferred here.

C. Employee benefits not subject to payroll taxes, such as uniforms or non-wage incentives, may be reported here in the appropriate cost area.

D. Supplies, Nursing and Medical – Report here supplies including, but not limited to, tongue depressors, swabs, Band-Aids, cotton balls, alcohol, and nursing reference books. Report nursing forms and medical records supplies in this item.

   a. Supplies that are chargeable to Medicare or sources other than Medicaid are not to be included in this item.

E. Supplies, Office – Report office supplies in each setting as appropriate.

F. Supplies, Operational – include non-depreciable equipment required to maintain and repair departmental equipment, garbage cans/bags, and cleaning supplies used to keep operational areas clean.

11. Depreciation – Transportation Equipment – Enter all transportation equipment 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.

12. Rent/Lease – Transportation Equipment or Contracted Transportation Services –

A. Report transportation equipment lease/rental costs in this item.

B. Nonrelated-party rental or lease that is not a capital lease is reported here. All related-party rentals and leases and all capital leases, whether a related party or not, for transportation equipment that costs $5,000 or more and has a useful life of more than one year must be reported through **Step 8.e.**

C. Non-depreciable transportation equipment (costing less than $5,000 or with a useful life of less than one year) rented or leased from a related party must be reported through **Step 8.b.**

D. Contracted Transportation Services – may be a contract with a local taxi company to transport individuals, monthly passes for individuals on the bus system, or other contracts to provide transportation of individuals.

13. Transportation – Maintenance, Repairs, Gas, Oil, Interest, Insurance, Taxes, Other – Report transportation expenses related only to the delivery of NF services. If a vehicle is used for both personal and business use, vehicle logs must be maintained to document and remove expenses related to personal use.

    Grants and contracts from the federal, state, or local governments, such as transportation grants or Housing and Urban Development 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 example, if a grant was received from the Texas Department of Transportation (TX DOT) to assist in the purchase of a van, the amount of the grant would be deducted from the cost of the van, and only the remaining cost, if any, reported on the cost report as a depreciable asset.

A. Insurance, Vehicle – Report the cost for insurance premiums or allowable paid claims for vehicles in cases of self-insurance. Report only the portion of the insurance expense directly related to this NF contract. See Insurance – Building and Equipment above for details on proper reporting of Insurance expenses.

B. Interest, Vehicle Loans – Report the interest from loans for vehicles or for repairs/maintenance of vehicles used in the NF program. If a related party funded the loan, do not enter directly here. Enter through **Step 8.c**.

C. Property Tax, Vehicles - Report property tax paid on vehicles used in the NF program.

D. Maintenance, Repairs, Gas, and Oil – Report the applicable amount of automobile expenses related to this program. Personal use of vehicles must be documented and removed from the cost report. Repairs and maintenance expenses are categorized as ordinary or extraordinary repairs for cost-reporting purposes.

    a. Ordinary transportation equipment repairs and maintenance are defined as outlays for parts, labor, and related supplies that are necessary to keep an asset in operating condition but neither add materially to the use value of the asset nor prolong its life appreciably. Ordinary repairs include tune-ups, oil changes, cleaning, inspections, and replacement of parts due to normal wear and tear (such as tires, brakes, shocks, and exhaust components). Ordinary repairs may be expensed in the year the expense is accrued and reported directly in this item.

b. Extraordinary or major vehicle repairs involve relatively large expenditures, are not normally recurring, and usually, increase the use value or the service life of an asset beyond what it was before the repair. Extraordinary repairs include such things as engine and transmission overhaul and replacement. Extraordinary repairs that cost $1,000 or more and have a useful life in excess of one year may not be reported directly in this item. They must be capitalized and depreciated by reporting in **Step 8e**. See 1 TAC Section 355.103(b)(9)(B).

E. Other Transportation Expenses – Expenses such as license tags, parking fees, and tolls should be reported in this item. Parking fines or penalties are not allowable costs and should not be in this cost report. Provide an itemization of each category of expense and its associated dollar amount in the Notes section.

14. Staff Training/Seminars – To be allowable, the training must be located within the state of Texas (unless not available in Texas) and be related directly and primarily to the job being performed by the staff person attending the training.

A. For training conducted within the provider setting, allowable training costs include, but are not limited to, instructor and consultant fees, training supplies, and visual aids.

B. For off-site training, allowable costs include costs such as allowable travel costs (which are to be reported in 2022. Travel, below), registration fees, seminar supplies, and classroom costs; and meet the other criteria detailed in 1 TAC Section 355.103(b)(15).

C. Training/Seminar costs incurred for Program Administration and Operations and Central Office staff are reported in their respective cost areas.

D. Costs for training outside the continental United States are unallowable.

15. Staff Training / Seminars - Admin - Report training and seminar costs for Administrative Staff here. The same criteria in Item 14 above apply.

16. Insurance – Liability – See 1 TAC Section 355.103(b)(13).

A. In this item, report the cost for insurance premiums for general liability and professional malpractice insurance paid to a nonrelated insurance company, but only in Program Administration and/or Central Office as appropriate. Also, report the premiums paid to a risk retention group registered with the Texas Department of Insurance.

B. Costs related to errors and omissions (liability) insurance for board members are allowable.

C. Costs paid to a related-party insurance company for liability insurance will not be reported directly in this item. Report those costs through **Step 8.d**.

D. Report the cost for paid claims, deductibles, and co-insurance for general liability and professional malpractice insurance. The cost of claims paid under a captive insurance arrangement must be reported here.

17. Travel (not to include mileage reimbursement)

For purposes of training, allowable travel must be within the state of Texas (unless not available in Texas), be related directly and primarily to the job being performed by the staff person attending the training, and meet the other criteria detailed in 1 TAC Section 355.103(b)(15).

Other than mileage reimbursement, which is to be reported in **Step 6** with the costs for the various staff types, allowable travel for purposes other than training must be related directly and primarily to the job being performed by the staff person. Such travel must be within the state of Texas except for travel for the purpose of delivering direct contracted client services within 25 miles of the Texas border with adjoining states or Mexico; or the purpose for the travel is to conduct business related to contracted client services in Texas, and the travel is between Texas and the contracted provider's central office. All costs for travel outside the continental United States are unallowable costs, with the singular exception of travel required for the delivery of directly contracted client services within 25 miles of the Texas-Mexico border.

The maximum for lodging per diem and meals per diem costs is 150% of the General Services Administration (GSA)'s federal travel rates to determine the maximum lodging and meals reimbursement rates.
The GSA's website is: http://www.gsa.gov/portal/category/21287

Once the provider accesses this website, they must select the correct time period from the "Find rates for the fiscal year" box, remembering that federal fiscal years begin in October and end in September. For example, federal fiscal year 2022 began on October 1, 2021, and ended on September 30, 2022.

After selecting the correct time period, the provider must click on the picture of the state of Texas, identify the maximum lodging and meals rates for the location of their travel lodging from the table, and multiply those amounts by 1.5. The results are the maximum allowable per diem for lodging (plus applicable city/local/state taxes and energy surcharges) and meals. Tips and alcoholic beverages are not allowable meal costs.

18. Fees – Management Contract – See 1 TAC Sections 355.103(b)(6) and 1 TAC 355.105(b)(2)(B)(xiii).

A. Reasonable management fees paid to non-related parties are allowable costs. If the contracted provider has a management agreement with a nonrelated business entity to provide management services to the contracts, include in the Cost Report

Group, report the fees incurred here and upload a copy of the management agreement signed by all interested parties. If an expense is reported in this item, **Step 6.a.,** *Question 1 Do you have any contracted management costs to report?* Must be "Yes".

B. If the contracted manager was designated in **Step 6.a.** as a related party, do not enter those costs here. Allowable management fees paid to related parties for administrative services are limited to the actual costs (e.g., staff, supplies, materials, allocated building costs, allocated departmental equipment costs) incurred by the related-party manager for services provided. Related-party management costs must be reported as central office costs with no markup in the specific items related to the cost and must not be combined into one item.

19. Fees – Contracted Administrative, Professional, Consulting, and Training Services – See 1 TAC Section 355.103(b)(2)(C).

A. Contracted medical records services – Report here.

B. Contracted administrative services, such as clerical temporaries, printing services, copying services, and courier delivery services – Report here.

C. Report the cost of contracted professional services, including allowable expenses related to accountants, attorneys, and data processing. Accounting fees for preparing income tax forms and returns are allowable costs; however, income taxes are not allowable. See 1 TAC Sections 355.103(b)(3) and 1 TAC 355.105(b)(2)(B)(viii). Professional service fees must be directly related to the provider's activity only and directly or indirectly related to the provision of services included in the vendor payment.

D. Legal, accounting, and other fees and costs associated with litigation between a provider and a governmental entity are unallowable costs. According to 1 TAC Sections 355.103(b)(2)(C)(ii) and 355.103(b)(17)(I), the costs of litigation that resulted in a court-ordered award of damages or settlements to be paid by the provider or that resulted in a criminal conviction of the provider are unallowable costs. Within the narrow range of circumstances where legal expenses are allowable on the Cost Report, adequate documentation must be maintained as described in 1 TAC Section 355.105(b)(2)(B)(viii). Expenses incurred because of imprudent business practices are unallowable.

E. Allowable expenses for workers' compensation administrative and legal expenses are to be reported here.

F. Allowable franchise fees should be reported here. Franchise fees differ from franchise taxes; see Taxes – Texas Corporate Franchise Tax below. Franchise fees representing "goodwill" or other intangible services are not allowable. See 1 TAC Section 355.103(b)(20)(C).

G. Report seminar/conference registration fees as training and seminar costs in Staff Training/Seminar above.

H. The following costs are unallowable and are not to be reported on this cost report: "NSF" (insufficient fund) charges and other penalties; fees paid to members of the provider's board of directors; and administrative fines and penalties.

20. Licenses and Permits – Include fees for licenses and permits, license fees paid on behalf of an employee (e.g., Administrator license), and HHSC assessments per bed.

21. Interest – Other (describe)

A. Maintain adequate documentation and report the cost of interest paid on working capital loans (e.g., lines of credit). If a related-party funded loan, do not enter here directly. Enter through **Step 8.c**.

B. Any interest income must offset the interest expense reported in this item, and only the remaining interest expense, if any, is reported here.

22. Taxes – Texas Corporate Franchise Tax – See 1 TAC Section 355.103(b)(12). Report the cost of Texas corporate franchise tax expenses for the cost-reporting period only. This item should not be blank if the provider is a corporate entity. If a tax statement includes any period of time outside the cost-reporting period, the cost must be prorated so that the amount reported on the cost report represents only costs associated with the cost-reporting period. Franchise taxes differ from franchise fees; allowable franchise fees are reported in Fees – Contracted Administrative, Professional, Consulting, and Training Services above. Franchise taxes associated with states other than Texas are unallowable costs.

23. Taxes – Other (describe) – See 1 TAC Section 355.103(b)(12).

A. Personal property taxes related to the contents of the NF building and other operational taxes associated with the NF building only.

B. Unallowable taxes include federal, state, and local income taxes; excess profit or surplus revenue-based taxes; taxes levied on assets not related to the delivery of Medicaid-contracted NF services in Texas; pass-through taxes, such as sales tax collected and remitted; and tax penalties and interest. Self-employment taxes are unallowable. Taxes for which an exemption is available are unallowable.

C. Taxes in connection with the financing, refinancing, or refunding operations, such as taxes on the issuance of bonds, property transfers, and issuance or transfer of stocks, are unallowable as a tax expense; however, such taxes are usually depreciated or amortized.

D. Ad valorem property taxes are reported in Taxes Ad Valorem Real Estate above.

E. Texas corporate franchise taxes are reported in Taxes–Texas Corporate Franchise Tax above.

24. Advertising – See 1 TAC Section 355.103(b)(16) for a complete description of allowable and unallowable advertising and public relations expenses. Advertising expenses for recruitment of necessary personnel, yellow page listings no larger than one-eighth of a page, advertising to meet statutory or regulatory requirements, and advertising for the procurement of items related to contracted resident care are allowable costs.

25. Dues and Memberships – See 1 TAC Section 355.103(b)(14).

    A. Dues for membership in professional associations directly and primarily concerned with the provision of NF services for which the provider is contracted are allowable. Any portion of the cost for membership that is applied to lobbying or whose purpose is to fund lawsuits or any legal action against the state or federal government is not allowable.

    B. Dues for membership in purchasing organizations or buying clubs are limited to the prorated amount representing purchases made for use in providing contracted services.

    C. Subscriptions to newspapers, journals, and magazines whose content is primarily concerned with the provision of services for which the provider is contracted are allowable and should be reported in the cost area where the salaries of the employees using those subscriptions are reported (i.e., Program Administration and/or Central Office).

    D. Dues or contributions made to any type of civic, political, social, fraternal, or charitable organization are unallowable. Chamber of Commerce dues are unallowable.

26. Other (describe) – Report here any costs that cannot be reasonably reported in any prior cost category. Any cost reported here should be adequately described. Costs related to boards of directors are unallowable, with the exception of travel costs incurred to attend meetings of the contracted provider's board of directors or trustees, within limits (reported in Travel above) and errors and omissions (liability) insurance for board members (reported in Insurance – Liability above).

27. Consultants - Enter here the cost for Non-Related Party Consultants for Medical Director, Registered Nurse, Pharmacist, Social Worker, Activity Director, Medical Records, and Other Resident Care Consultants (provide a description in the Notes box).

28. Contracted Services (Non-Related Party Contracted Costs for Participants in the Direct Care Staff Compensation Rate Enhancement – See 1 TAC Section 355.112(ff)). - For **Participants** in the Direct Care Staff Compensation Rate Enhancement, report the days and payments to the third-party contractor here. HHSC will allocate 50% of reported payments to the direct care staff compensation cost area for inclusion with other allowable direct care staff costs to determine the total direct care staff compensation spending. For contracts with a related organization, the properly

allocated Administration, Facility, and Operations costs of the related organization will be reported in the correct cost area and line items as if they are costs of the NF and not in this item.

29. Supplies – Report the costs of nursing and medical supplies, resident care staff in-service training supplies, activities supplies, social services supplies, and laundry and housekeeping supplies. Report only net expenses, meaning gross expenses less any purchase discounts, rebates, returns, or allowances.

    A. Nursing and medical supplies include, but are not limited to, tongue depressors, swabs, Band-Aids, cotton balls, alcohol, disposable briefs (diapers), personal hygiene items, and nursing reference books. Include medical accessories prescribed by the attending physician (such as cannulas, tubes, masks, IV fluids, and IV equipment). Include all non-legend ("over-the-counter") drugs. Include, for Medicaid residents, those prescription drugs not covered by the Texas Vendor Drug Program. Also include alcoholic beverages prescribed by a physician for medicinal purposes. Insulin costs are unallowable and are not to be included on this cost report. Medical and nursing supplies that are chargeable to Medicare or sources other than Medicaid are not to be included on this item. Instead, they are to be reported on Schedule G. See the instructions for Schedule G for additional information. An exception would be disposable briefs (diapers) and routine medical supplies (not historically chargeable as ancillaries to Medicare or other non-Medicaid sources) provided to non-Medicaid residents for which a charge is made. Because these supplies are considered routine items that must be provided to Medicaid residents at no additional charge, treat these charges as routine by adding them to the routine revenues reported in the appropriate resident category and reporting associated costs.

    B. Activity Supplies – report costs for television cable if available to all residents; newspaper and magazine subscriptions for resident use; and food, toys, supplies, and veterinary expenses for pets housed in the facility for the enjoyment of residents.

    C. Laundry and Housekeeping – report costs for linen and bedding (e.g., sheets, spreads, bath towels, and hand towels).

30. Off-site Training/Seminars & Travel - Resident Care Staff - report costs incurred for Resident Care Staff while attending training outside the facility. To be allowable, the training must be located within the state of Texas (unless not available in Texas), be related directly and primarily to resident care, limited to the cost of registration fees, transportation, meals and lodging, and meet the other criteria detailed in 1 TAC Section 355.103(b)(12). Training/Seminar costs incurred for administrative, maintenance, and other nonresident care staff are to be reported in item #14 or, #15 above as appropriate and are not to be included in this item. You will receive an

email from Fairbanks if additional information is requested. You will have 14 days to respond and upload additional information upon request.

31. Bio-Hazard Waste Disposal - HHSC Regulatory rules mandate each contracted nursing home to follow infection control practices; therefore, a cost must be reported in this item. This item is sometimes referred to as "red bag" waste, including infectious waste bags and infection control book. This does not refer to garbage disposal, which is reported in item #6 above. If the facility does not have any biohazard waste disposal costs reported in this item, please include a message in the Notes box to explain why there are no such costs to be reported on this cost report.

32. Other Resident Care Expenses - Report costs related to medical record supplies and non-depreciable equipment, contracted medical records services, supplies used to administer Hepatitis B vaccinations to facilitate resident care staff, costs associated with TB tests, chest x-rays, drug tests, and physicals for facility resident care staff, resident care staff employee benefits not subject to payroll taxes (e.g., uniforms), and other nursing expenses (such as ambulance service costs) that are not associated with the expense categories for items **Step 6.c.**, **Step 6.d.** or in #18 above. Do not report oxygen costs in this item; oxygen is an ancillary service and must be reported on Schedule G and carried over into item #39 below. Do not report costs for Hepatitis B vaccinations, TB tests, etc., for nonresident care staff on this item; rather, report such costs for dietary staff on item #43 below, for maintenance staff in item #7 above, for administrative staff in item #29 above, and for central office staffing in item #26 above. Do not include any salaries/wages in this item. This item does not include any facility costs (e.g., maintenance supplies or repairs and maintenance) or administrative expenses (e.g., license fees or advertising). Do not report employment ads for nursing staff in this item; such costs should be reported in item #24 or #26 above, as appropriate.

33. Therapy Supplies - Include here therapy supplies for Physical, Occupational & Speech Therapy. Do not include Nutritional Therapy Supplies; include those in Item # 36 below.

34. Consultants - Physical, Occupational & Speech Therapy - Report salaries and wages for Physical, Occupational, and Speech Therapists; also report the cost of consultants, contracts, and off-site therapy.

    A. Physical Therapy costs include salaries and wages for physical therapists and physical therapy assistants licensed as physical therapists by the Texas State Board of Physical Therapy Examiners and the cost of physical therapy consultants.

    B. Occupational Therapy costs include salaries and wages for occupational therapists and occupational therapy assistants licensed by the Texas Board of Occupational Therapy Examiners and the cost of occupational therapy consultants.

    Speech Therapy costs include salaries and wages for speech-language pathologists who are Texas licensed speech-language pathologists or who meet the educational

requirements for a 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 the cost of speech therapy consultants.

35. Contract and Off-Site Therapy - Report here Physical, Occupational, and Speech Therapy costs for contract and off-site therapy.

36. Supplies: Nutritional Therapy Supplies, Medical, Nursing & Incontinent - Nutritional Therapy Food Supplies include the costs of parenteral and enteral nutritional products. Do not include the costs of supplies and specialized staff related to the delivery of these products to the resident; those costs should be reported in Item #43 below. "Ensure" and similar products are not considered ancillary products, and the costs of "Ensure," etc., should be reported as Supplies/Other Dietary Costs in Step 8f.

37. 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. 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 11. 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 11. Personnel costs related to these items are to be transferred from Column G to item Step 6, while other related costs are to be transferred from Column G to here.

38. 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 here.

39. Oxygen - Include here the expense incurred for providing physician-ordered oxygen to Medicaid-only residents. Equipment costing less than $5,000 or with a useful life of less than one year and supplies associated with the delivery of oxygen may be included here as well. Enter equipment that costs $5,000 or more and has a useful life of more than one year associated with delivering oxygen to residents in Step 8e.

40. DME Purchased by Provider - Chargeable DME and Equipment Rental include 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 in Step 8.e., General use wheelchairs and hospital beds not prescribed by a physician are not considered DME and should not be depreciated as departmental equipment (item #9 above).

41. Durable Medical Equipment (DME) Rental/Lease Expense

Report here your DME rental and lease expenses. Included in DME are wheelchairs, walkers, and hospital beds.

42. Contract Dietary Services - See 1 TAC Section 355.102(b)(2)(C). Report on this item the cost incurred for dietary contract 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.
43. 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 cost 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. Nondepreciable equipment should be reported as supplies in this item. Effective for purchases made on or after the beginning date of the provider's 2022 fiscal year, non-depreciable equipment is equipment that costs less than $5,000 or has a useful life of less than one year, whereas depreciable equipment is equipment that costs $5,000 or more and has a useful life of more than one year. As well, purchases made before the provider's 2022 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 contract in the provider's fiscal year 2022, 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. Nondepreciable repairs and maintenance costs for departmental dietary equipment should be reported in item #10 above; depreciable repairs and maintenance costs for departmental dietary equipment should be reported in item #7 above.

Step 8.g. Facility and Operations Costs Summary

Purpose

This Step provides a summary of the Related and Non-Related-Party Costs entered through **Steps 8.b.-8. f.**

8.g. Facility and Operations Costs Summary

	Related and Non-Related Party Summary		
Type	**Program Admin & Operation**	**Central Office**	**TOTAL**
Rent / Lease - Building and Building Equipment			
Rent / Lease - Departmental Equipment / Other			
Interest - Mortgage			
Insurance - Building and Equipment			
Taxes - Ad Valorem Real Estate			
Utilities & Telecommunications			
Building / Equipment - Contracted Services and Maintenance and Repairs			

	Related and Non-Related Party Summary		
Type	**Program Admin & Operation**	**Central Office**	**TOTAL**
Depreciation - Building & Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, Other Amortization			
Depreciation - Departmental Equipment			
Other Non-Depreciable Equipment and Operations Supplies			
Depreciation - Transportation Equipment			
Rent / Lease - Transportation Equipment or Contracted Transportation Services			
Transportation - Maintenance, Repairs, Gas, Oil, Interest, Insurance, Taxes, Other			
Staff Training / Seminars - Non Admin Staff			
Staff Training / Seminars - Admin			

	Related and Non-Related Party Summary		
Type	**Program Admin & Operation**	**Central Office**	**TOTAL**
Insurance - Liability			
Travel (not to include mileage reimbursement)			
Fees - Management Contract			
Fees - Contracted Administrative, Professional, Consulting and Training Services			
Licenses and Permits			
Interest - Other			
Taxes - Texas Corporate Franchise Tax			

	Related and Non-Related Party Summary		
Type	**Program Admin & Operation**	**Central Office**	**TOTAL**
Taxes - Other (describe) :			
Advertising			
Dues and Memberships			
Other (describe) :			

	Related and Non-Related Party Summary		
Type	**Program Admin & Operation**	**Central Office**	**TOTAL**
Consultants			
Contracted Services			
Supplies			
Off-site Training/Seminars & Travel - Resident Care Staff			
Bio-Hazard Waste Disposal			
Other Resident Care Expenses			

	Related and Non-Related Party Summary		
Type	**Program Admin & Operation**	**Central Office**	**TOTAL**
Therapy Supplies			
Consultants - Physical, Occupational & Speech Therapy			
Contract and Off-Site Therapy			
Supplies: Nutritional Therapy Supplies, Medical, Nursing & Incontinent			
Diagnostic Laboratory and Radiology			
Drugs and Pharmaceuticals			
Oxygen			
DME Purchased by Provider			
DME Rental/Lease Expense			

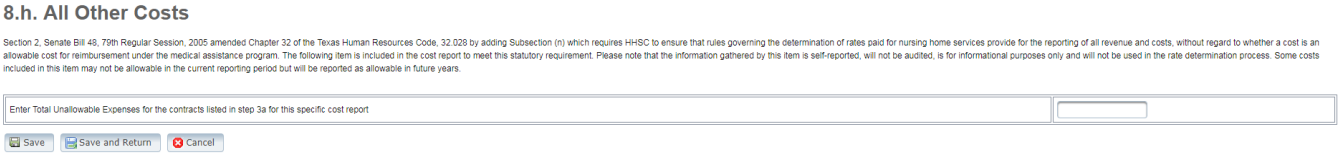
	Related and Non-Related Party Summary		
Type	**Program Admin & Operation**	**Central Office**	**TOTAL**
Contract Dietary Services			
Supplies/Other Dietary Costs			
TOTAL			

Save | Save and Return | Cancel

Step 8.h All Other Costs

Note: The information gathered by this item is self-reported, will not be audited, is for informational purposes only, and will not be used in the rate determination process.

Enter Total Unallowable Expenses for the contracts listed in Step 3.a. for this specific cost report.



Step 9. Preparer Verification Summary

Purpose

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

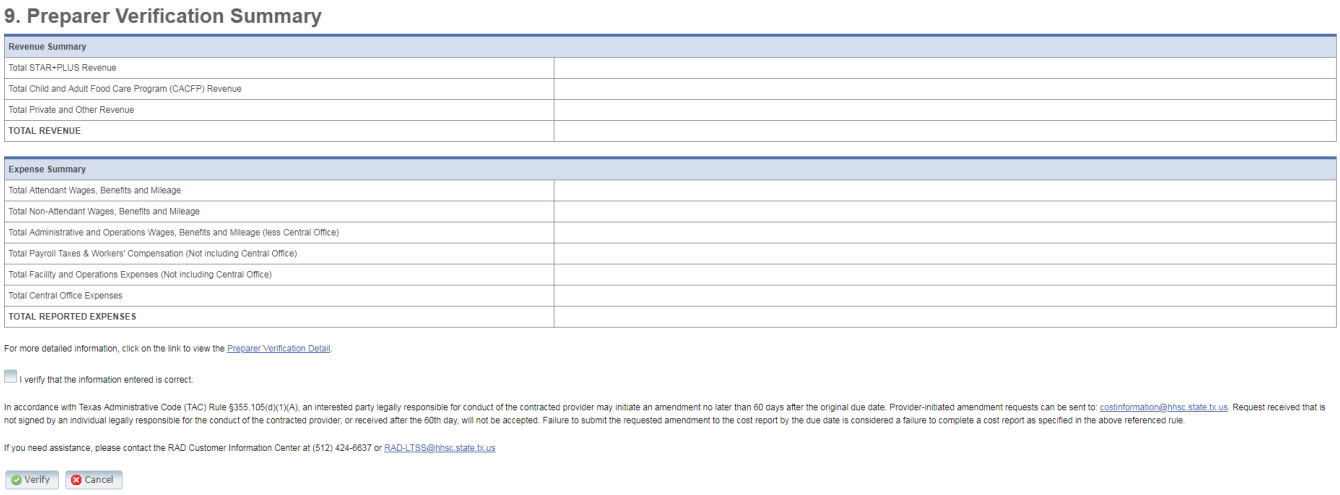
How do we use this information?

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

How to complete Step 9

After all items for the cost 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 ensure that all intended non-HHSC revenues and expenses have been entered.

Expenses entered into STAIRS. These figures should be checked against the preparer's work papers to ensure that all intended non-Medicaid revenues and expenses have been entered.



9. Preparer Verification Summary

Revenue Summary	
Total STAR+PLUS Revenue	
Total Child and Adult Food Care Program (CACFP) Revenue	
Total Private and Other Revenue	
TOTAL REVENUE	

Expense Summary	
Total Attendant Wages, Benefits and Mileage	
Total Non-Attendant Wages, Benefits and Mileage	
Total Administrative and Operations Wages, Benefits and Mileage (less Central Office)	
Total Payroll Taxes & Workers' Compensation (Not including Central Office)	
Total Facility and Operations Expenses (Not including Central Office)	
Total Central Office Expenses	
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

Verify Cancel

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

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

Steps 10 and 11. Preparer Certification and Entity Contact Certification

Purpose

Providers must certify the accuracy of cost reports submitted to HHSC. Providers may be liable for civil and/or criminal penalties if the cost report is not completed according to

HHSC requirements or is determined to contain misrepresented or falsified information. Cost report preparers must certify that they have read the cost determination process rules, the reimbursement methodology rules, the cost report cover letter, and cost report instructions and that they understand that the cost report must be prepared in accordance with the cost determination process rules, the reimbursement methodology rules, and cost report instructions.

A person with supervisory authority over the preparation of the cost report who reviewed the completed cost report may sign a certification page in addition to the actual preparer, as per 1 TAC Section 355.105(b)(3).

How do we use this information?

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

How to complete Step 10 and 11

Certification pages cannot be printed for signing and notarizing or digital signature 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.

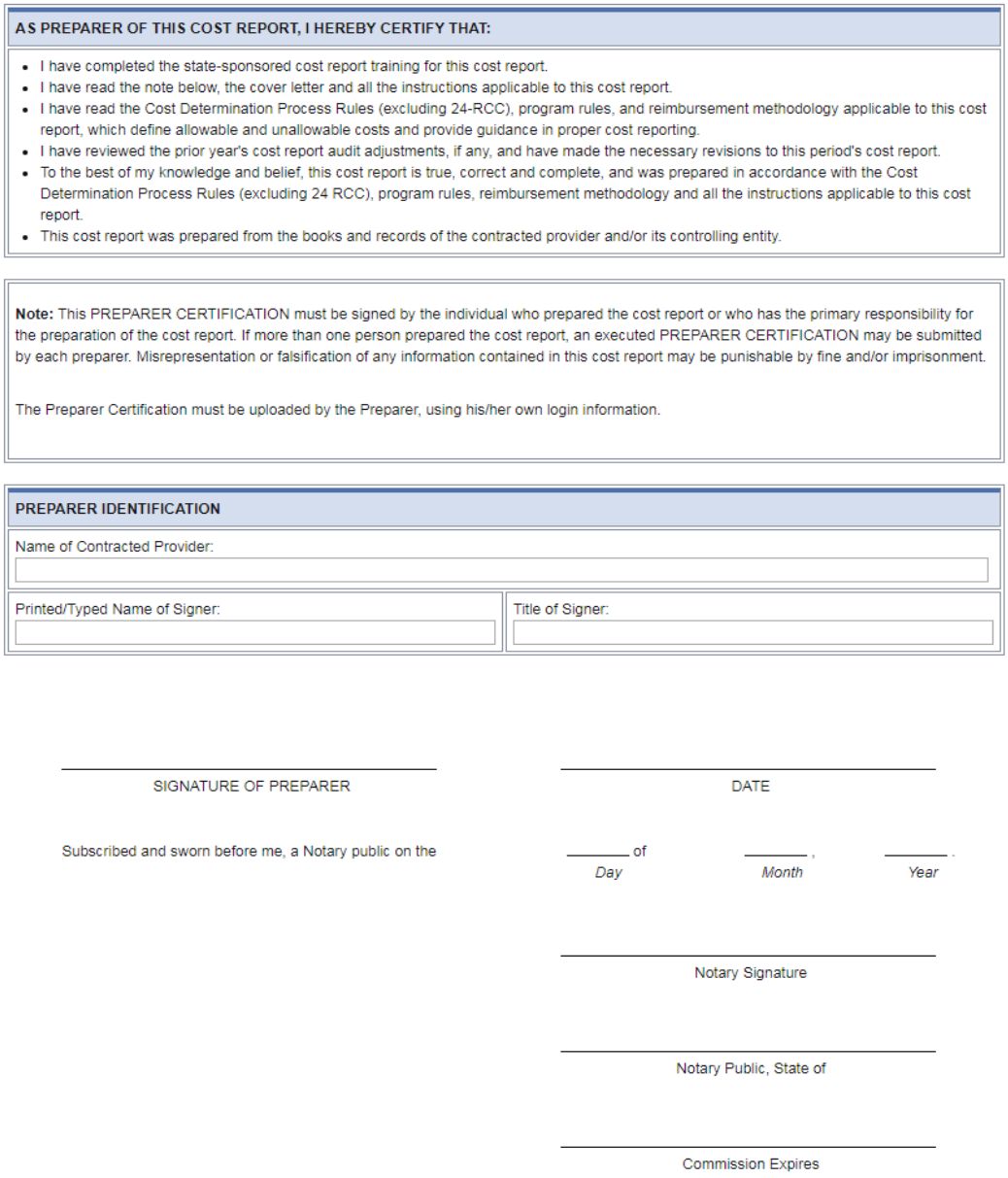
A preparer should not print the Preparer and Entity Contact Certification pages. The cost report is completed and locked. If it is discovered that additional changes need to be made, the preparer must contact costinformationPFD@hhs.texas.gov for assistance getting the report(s) reopened.

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

Step 10. Preparer Certification

Preparer (Methodology) Certification

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



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

- I have completed the state-sponsored cost report training for this cost report.
- I have read the note below, the cover letter and all the instructions applicable to this cost 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 cost 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

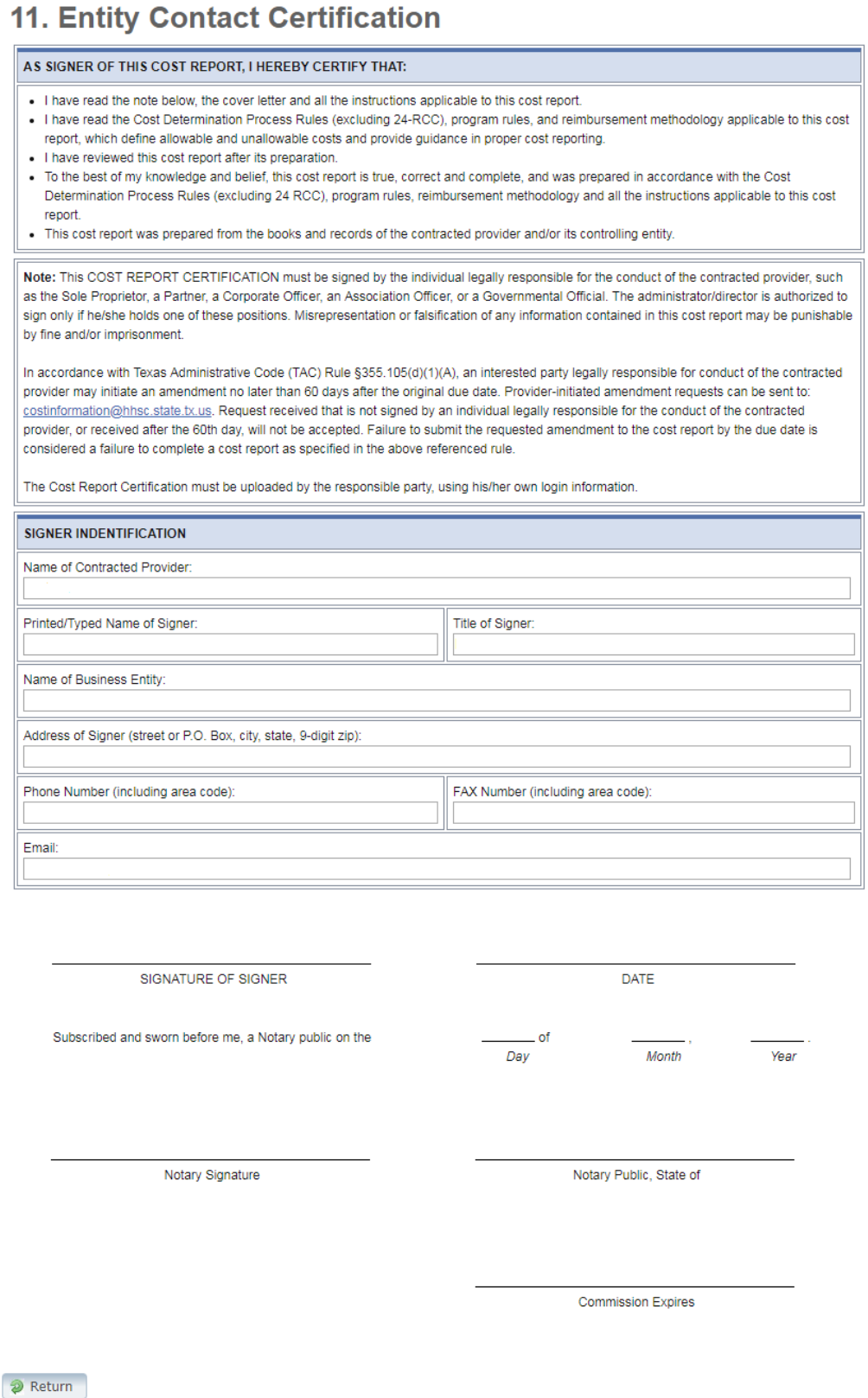
Notary Public, State of

Commission Expires

Step 11. Entity Contact Certification

Cost Report 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 included in the Cost 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 or digitally signed (Digital Signature Policy). The signature date must be the same or after the date the preparer signed the Methodology Certification page since the cost report certification indicates that the cost report has been reviewed after preparation.



11. Entity Contact Certification

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

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

The Cost 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

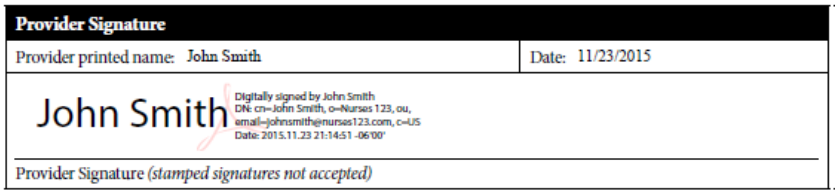
Notary Signature | Notary Public, State of

Commission Expires

Return

Digital Signatures

Per Texas Administrative Code (TAC) rule §355.105(b)(4), General Reporting and Documentation Requirements, Methods, and Procedures, cost report preparers must certify the accuracy of cost reports submitted to the Health and Human Services Commission (HHSC). Per the rule, this certification must: "contain a signed, notarized, original certification page or an electronic equivalent where such equivalents are specifically allowed under HHSC policies and procedures;"



HHSC will accept a digital signature if the signature is derived using software that creates a digital signature logo with a system-generated date and time stamp or includes the logo of the digital software used.

HHCS will not accept a digital signature if any of the following conditions apply, including, but not limited to:

- A photocopy of a handwritten signature
- An ink stamp of a handwritten signature
- A typed signature without a digital stamp

You may follow this link for more information. https://pfd.hhs.texas.gov/rate-analysis-digital-signature-policy

Step 12. Provider Adjustment Report

Purpose

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

The Provider has 30 days to review their adjustments. This is an opportunity to decide on an informal review in Step 13 or agree with the adjustment.

How to complete Step 12

This Step will not be visible until after the report has been reviewed and the provider is notified of adjustments to or exclusions of information initially submitted. Providers will receive an e-mail notification that their adjustment report is ready. The provider then has 30 days to review their adjustments. This entails clicking on step 12 and reviewing the adjustment report. Once you review Step 12 then, Step 13 will be available to Agree or

Disagree with the adjustments made. After the end of that 30-day period, the report will be set to the status of Agreed by Default.

Review Period Expires: February 04, 20XX

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

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

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

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

General and Statistical

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

Expenses

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

Revenues

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

Expenses

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

Revenues

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

Summary Table

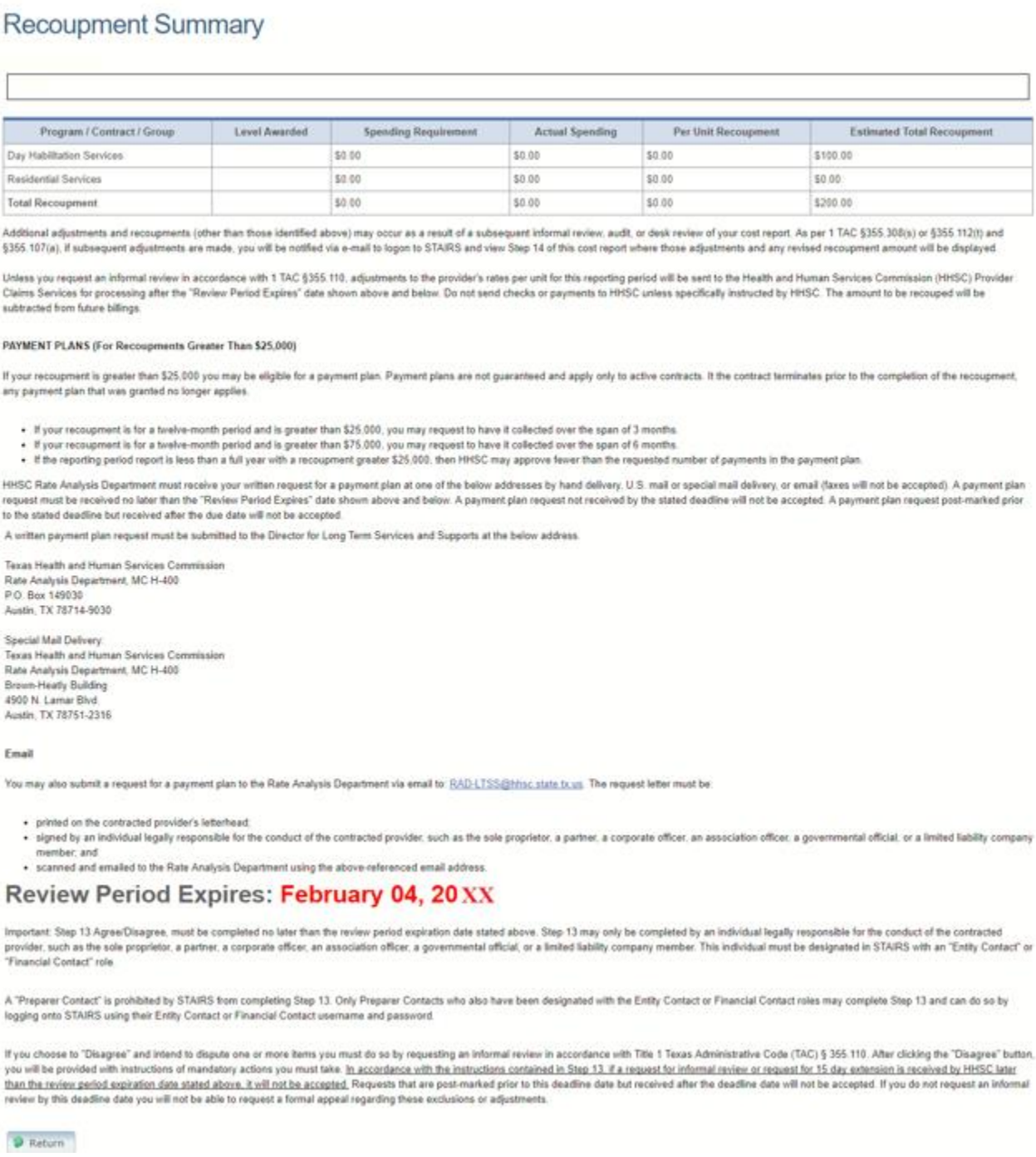
Revenue Summary	Total as Submitted	Adjustments	Total After Adjustments
Total Non-Medicaid	$0.00	$0.00	$0.00
Total	**$0.00**	**$0.00**	**$0.00**

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

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

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

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



Recoupment Summary

Recoupment Summary

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

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

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

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

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

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

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

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.

Review Period Expires: February 04, 20XX

Important: Step 13 Agree/Disagree, must be completed no later than the review period expiration date stated above. Step 13 may only be completed by an individual legally responsible for the conduct of the contracted provider, such as the sole proprietor, a partner, a corporate officer, an association officer, a governmental official, or a limited liability company member. This individual must be designated in STAIRS with an "Entity Contact" or "Financial Contact" role.

A "Preparer Contact" is prohibited by STAIRS from completing Step 13. Only Preparer Contacts who also have been designated with the Entity Contact or Financial Contact roles may complete Step 13 and can do so by logging onto STAIRS using their Entity Contact or Financial Contact username and password.

If you choose to "Disagree" and intend to dispute one or more items you must do so by requesting an informal review in accordance with Title 1 Texas Administrative Code (TAC) § 355.110. After clicking the "Disagree" button, you will be provided with instructions of mandatory actions you must take. In accordance with the instructions contained in Step 13, if a request for informal review or request for 15 day extension is received by HHSC later than the review period expiration date stated above, it will not be accepted. Requests that are post-marked prior to this deadline date but received after the deadline date will not be accepted. If you do not request an informal review by this deadline date you will not be able to request a formal appeal regarding these exclusions or adjustments.

Return

Recoupment Summary

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

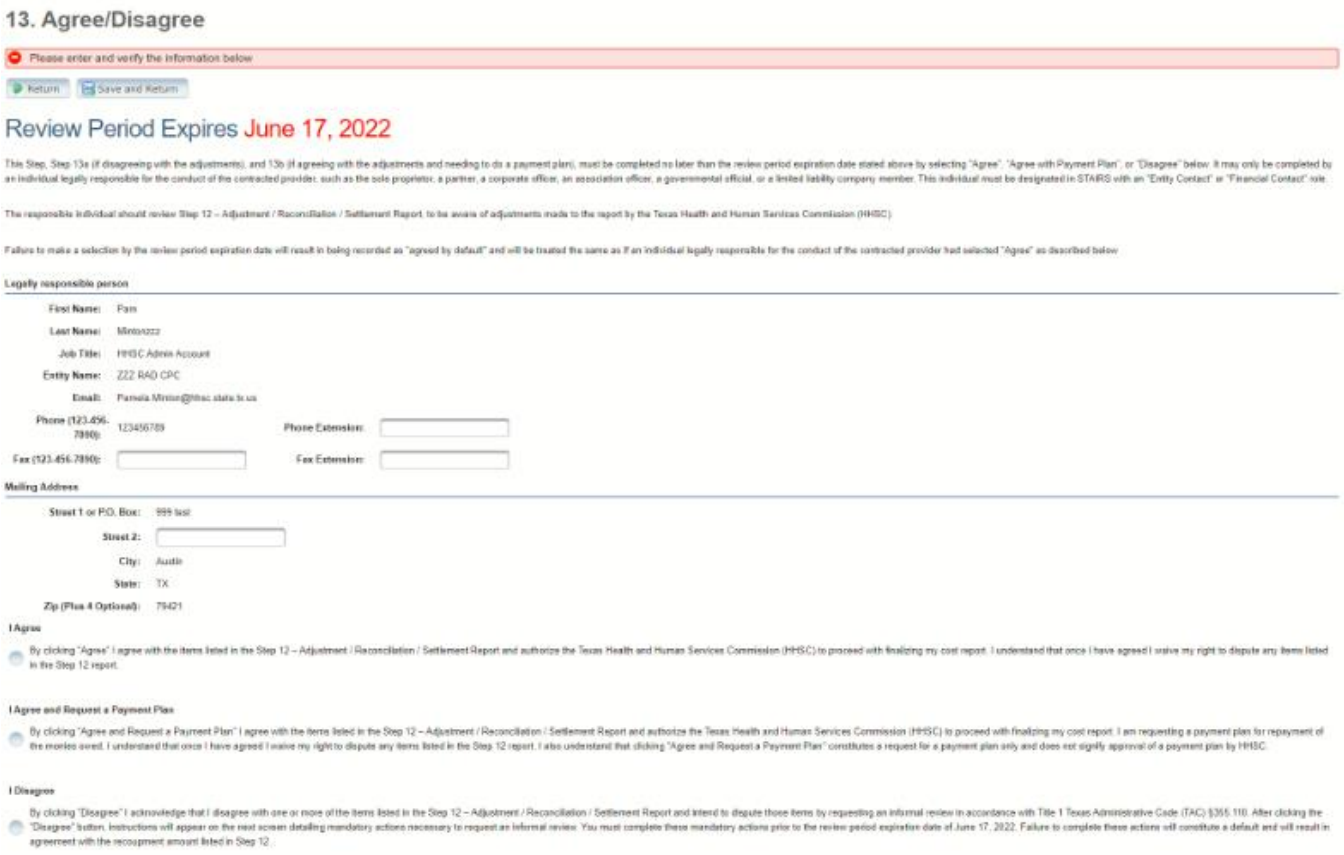
Step 13. Agree/Disagree

Purpose

Step 13 is for the provider to either agree, request a payment plan or disagree with the adjustments after reviewing the report.

How do we use this information?

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


13. Agree/Disagree

Please enter and verify the information below

Return | Save and Return

Review Period Expires June 17, 2022

This Step, Step 13a (if disagreeing with the adjustments), and 13b (if agreeing with the adjustments and needing to do a payment plan), must be completed no later than the review period expiration date stated above by selecting "Agree", "Agree with Payment Plan", or "Disagree" below. It may only be completed by an individual legally responsible for the conduct of the contracted provider, such as the sole proprietor, a partner, a corporate officer, an association officer, a governmental official, or a limited liability company member. This individual must be designated in STAIRS with an "Entity Contact" or "Financial Contact" role.

The responsible individual should review Step 12 – Adjustment / Reconciliation / Settlement Report, to be aware of adjustments made to the report by the Texas Health and Human Services Commission (HHSC).

Failure to make a selection by the review period expiration date will result in being recorded as "agreed by default" and will be treated the same as if an individual legally responsible for the conduct of the contracted provider had selected "Agree" as described below.

Legally responsible person

First Name: Pam
Last Name: Minton222
Job Title: HHSC Admin Account
Entity Name: Z22 RAD CPC
Email: Pamela.Minton@hhsc.state.tx.us
Phone (123-456-7890): 12345678 Phone Extension:
Fax (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

I Agree

By clicking "Agree" I agree with the items listed in the Step 12 – Adjustment / Reconciliation / Settlement Report and authorize the Texas Health and Human Services Commission (HHSC) to proceed with finalizing my cost report. I understand that once I have agreed I waive my right to dispute any items listed in the Step 12 report.

I Agree and Request a Payment Plan

By clicking "Agree and Request a Payment Plan" I agree with the items listed in the Step 12 – Adjustment / Reconciliation / Settlement Report and authorize the Texas Health and Human Services Commission (HHSC) to proceed with finalizing my cost report. I am requesting a payment plan for repayment of the monies owed. I understand that once I have agreed I waive my right to dispute any items listed in the Step 12 report. I also understand that clicking "Agree and Request a Payment Plan" constitutes a request for a payment plan only and does not signify approval of a payment plan by HHSC.

I Disagree

By clicking "Disagree" I acknowledge that I disagree with one or more of the items listed in the Step 12 – Adjustment / Reconciliation / Settlement Report and intend to dispute those items by requesting an informal review in accordance with Title 1 Texas Administrative Code (TAC) §355.110. After clicking the "Disagree" button, instructions will appear on the next screen detailing mandatory actions necessary to request an informal review. You must complete these mandatory actions prior to the review period expiration date of June 17, 2022. Failure to complete these actions will constitute a default and will result in agreement with the recoupment amount listed in Step 12.

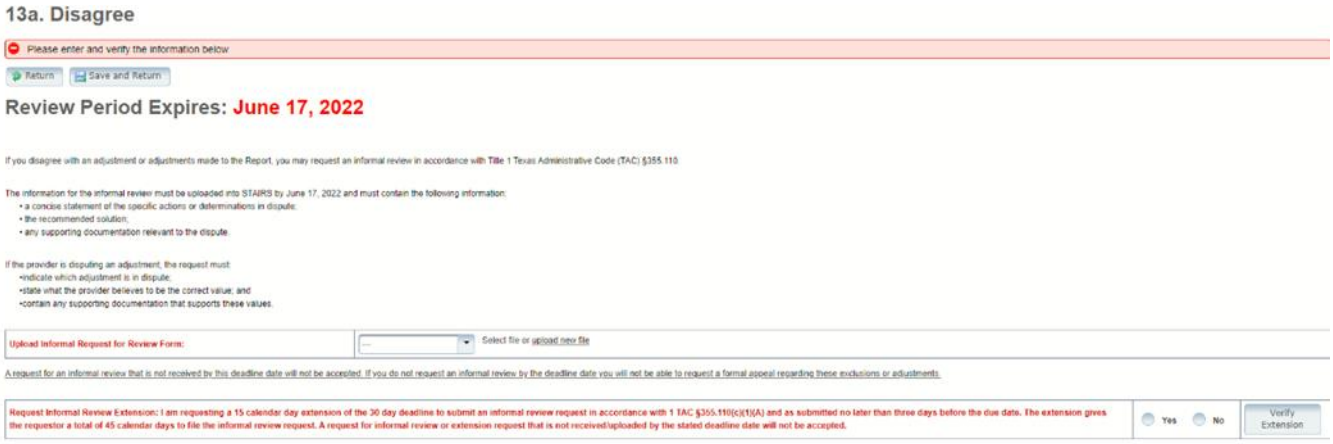
This Step will not be visible until after the report has been reviewed and the provider is notified of adjustments to or exclusions of information initially submitted. The Step may only be completed by an individual legally responsible for the conduct of the contracted provider, such as the sole proprietor,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

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

I agree

By choosing I agree, you are agreeing with the adjustments and finalizing the report. No further action is needed for this report.

Step 13a. I Disagree



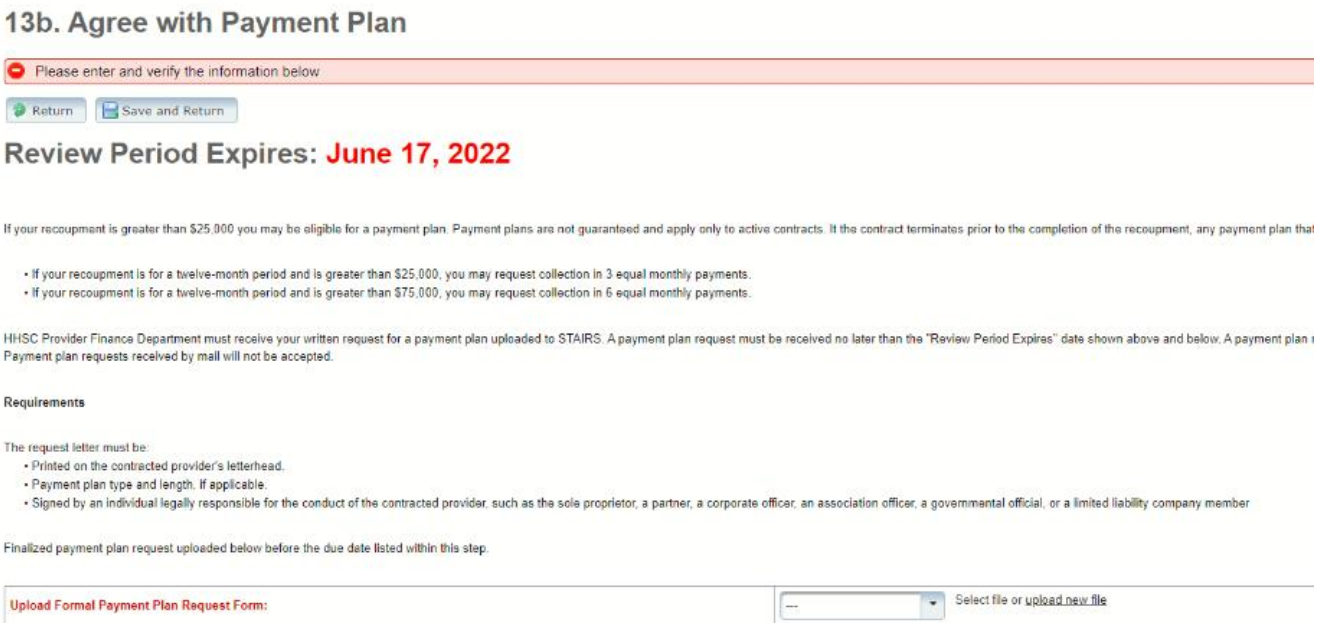
A provider who disagrees with an adjustment is entitled to request an informal review of those adjustments with which the provider disagrees. A provider cannot request an informal review merely by signifying the provider's Disagreement in **Step 13**. The request, or a request for a 15-day Provider disagree extension to make the request, must be uploaded into this section 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 Section 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.

This is also the section where you can file for a 15-day extension for the Informal Review.

Step 13b. I Agree and Request a Payment Plan



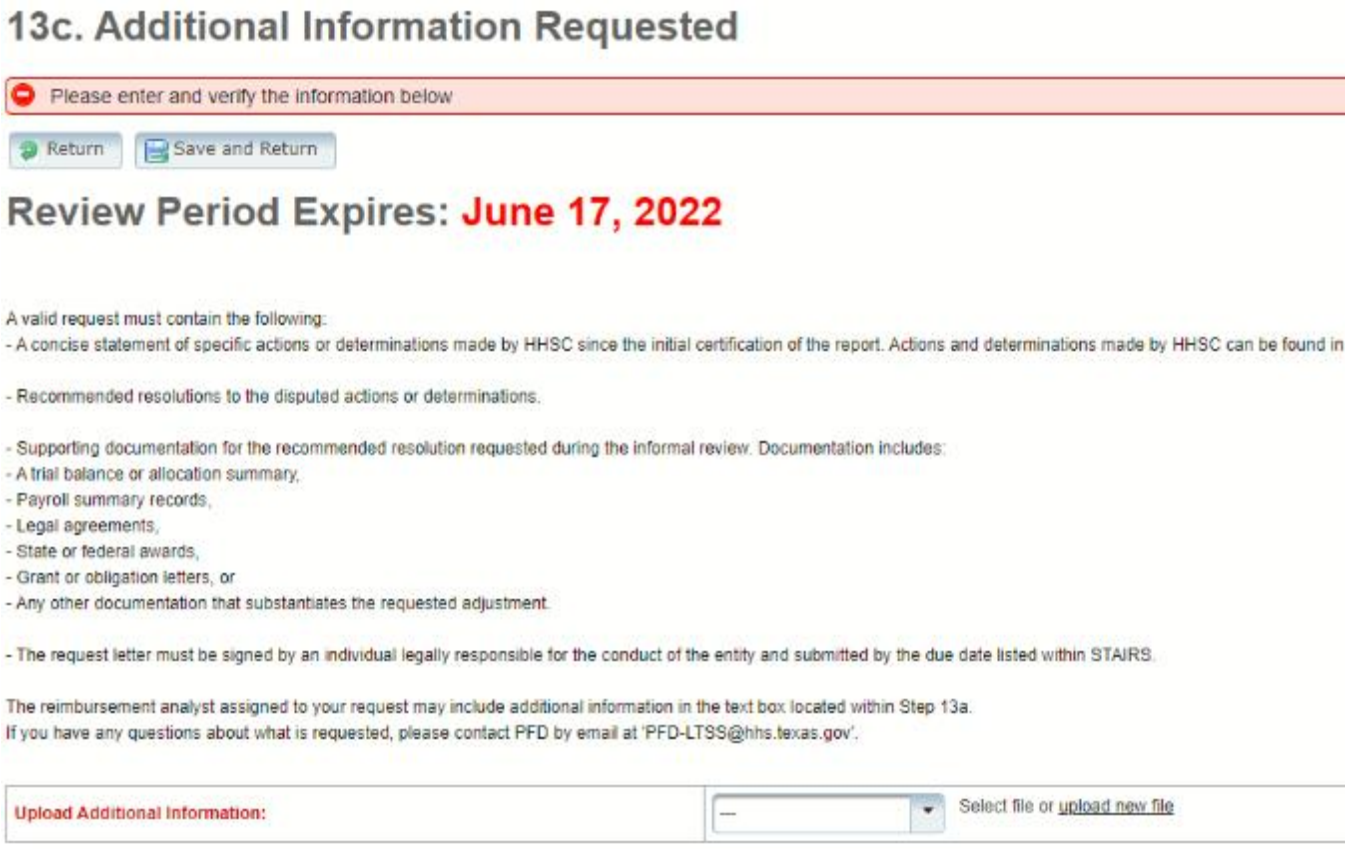
For providers with a recoupment amount above $25,000, the option "I Agree and Request a Payment Plan" will be available during Step 13. This option finalizes the report and requests a payment plan for paying the recoupment.

Once you click on, I Agree and Request a Payment Plan, there will be an option for you to upload the payment plan request. The payment plan request must follow these requirements: Is on the company letterhead

- Details what is being requested (a payment plan)
- Includes the Cost Report Group number or Contract number of the report
- Includes the year and type of report (Cost Report 2022, for example)
- It is signed by "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

Step 13c. Additonal Information Requested

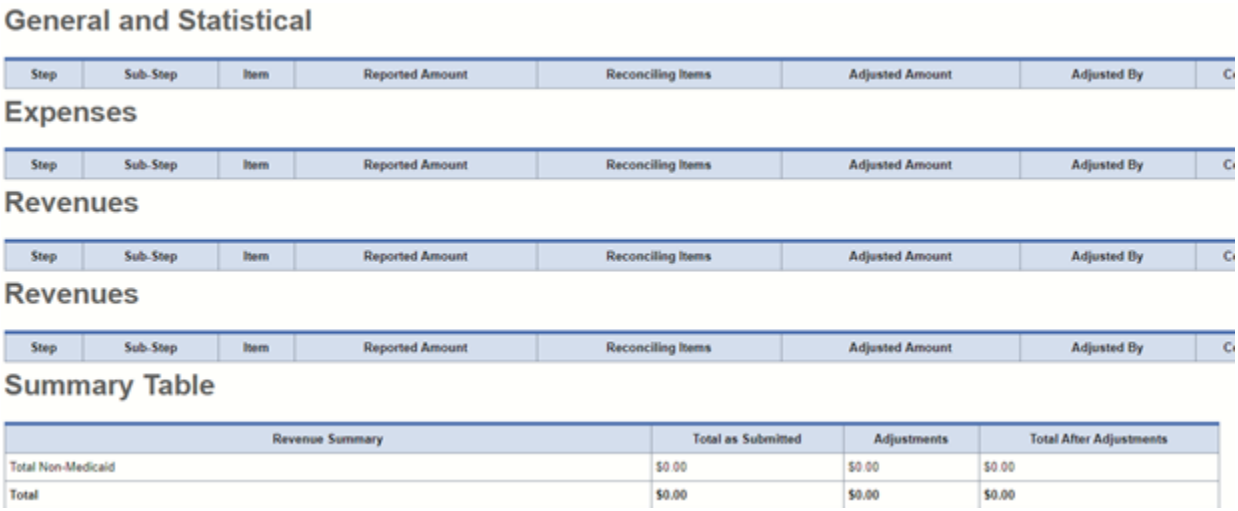
Step 13.c. will only appear if an informal review was requested and HHSC PFD is requesting more information. An email will be sent from Fairbanks if additional information is requested. You will have 14 days to respond and upload additional information upon request.



Step 14. HHSC Informal Review

Purpose

The purpose of this step is to allow the providers a chance to review the informal review adjustments.



General and Statistical

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

Expenses

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

Revenues

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

Revenues

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

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

Recoupment Summary

Recoupment Summary

Program / Contract / Group	Attendant Rate	Spending Requirement	Actual Spending	Per Unit Recoupment	Estimated Total Recoupment
NF					
Total Recoupment					

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

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

If your recoupment is greater than $25,000 you may be eligible for a payment plan. Payment plans are not guaranteed and apply only to active contracts. It 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, Rate Analysis Department at the below address.

Texas Health and Human Services Commission
Rate Analysis Department, MC H-400
P.O. Box 149030
Austin, TX 78714-9030
Special Mail Delivery:
Texas Health and Human Services Commission
Rate Analysis Department, MC H-400
Brown-Heatly Building
4900 N. Lamar Blvd.
Austin, TX 78751-2316

Email

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

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

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. The provider will not be able to access this Step until HHSC notifies the provider that adjustments are ready to be viewed.

APPENDIX A – Appendix A. Uploading Documents into STAIRS

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

All instructions for uploading documents into STAIRS, managing, and attaching those documents electronically, can be found in the STAIRS program by clicking on the Uploading File Instructions file under General Reference Materials at the bottom right-hand corner of any screen in STAIRS. The Upload Center can be located in STAIRS on the Dashboard by 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 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 on 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 than the 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 is following applicable rules or requires prior written approval from the HHSC Provider Finance, send an email to PFD-LTSS@hhs.texas.gov prior to submitting the cost report.

Time study: The time study must be in compliance with 1 TAC Section 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 and 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 Provider Finance before the end of the provider's fiscal year, as described at 1 TAC Section 355.102(j)(1)(D). To request such approval from HHSC PFD, submit and properly a disclosure statement along with justification for the change and explain how the new allocation method is in compliance with the Cost Determination Process Rules and how the new allocation method presents a more reasonable representation of actual operations.

If using an alternate allocation method, upload a properly cross-referenced copy of the provider's original allocation method approval request and any subsequent approval letter from 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 the proper allocation of shared costs, please contact the Provider Finance Center for Information and Training at PFD-LTSS@hhs.texas.gov.

TABLE 1. APPROPRIATE ALLOCATION METHODS FOR REPORTING

SHARED ADMINISTRATIVE COSTS THAT CAN NOT 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)	Functi
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*	Payro - Num check each compo the re period Purch Depar Numb purch proce the re period busine compo

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 reasonably reflect the provider's actual operations, the provider must use a method that does. If none of the listed methods reasonably reflect the provider's actual operations, contact the HHSC Provider Finance Center for Information and Training at PFD-LTSS@hhs.texas.gov for further instructions.

* See 1 TAC Section 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 - 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%

Allocation Summary - LABOR COST METHOD

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

							Allocated Shared Costs					
			Direct Costs			Shared	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 Unemployment	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

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 cost report. Shared dietary/central kitchen expenses must be reported on the cost report in the various items that reflect the types of expense (i.e., building depreciation, salaries, food, and 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.

A detailed allocation summary must accompany the allocation of these expenses. Cost 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 Sections 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 for all NF contracts, or
    b. Breakfast, lunch, and dinner for all NF contracts, or

c. Breakfast, lunch, dinner, and one snack for all NF contracts.

In certain situations, 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 daycare, and/or hospital), the shared dietary costs must be properly allocated using either 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 ICF/IID component. By multiplying the proportion of total weighted meals provided to the ICF/IID component for which the cost report preparer is completing the cost report by the various central kitchen costs, the cost report preparer can determine the central kitchen costs which should be reported on this cost 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 services (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 ICF/IID and a Day Activity and Health Services (DAHS)

Program which both serves 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 children

3-5 years old; a day care that serves to children 6-12 years old; and an ICF/IID 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
Total			10,402.00

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			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

	Total	3-5 yrs.	6-12 yrs.	NF
Central kitchen costs to be allocated:	100.00%	31.61%	22.96%	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 than 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 it takes to have the menu repeat, whether it is two weeks, a month, or some other period. If the menu or the menu cycle changes substantially (i.e., if child daycare 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 daycare, 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. Food invoices and other supporting documentation should document raw food costs.

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	NF	DAHS/NF	DAHS/NF	NF	NF	Total
	a.m. Snack Kitchen	Breakfast	Noon Meal	p.m. Snack		Evening Meal	Evening Snack
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%	7.66%	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.

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 Kitchen	NF Breakfast	DAHS/NF Noon Meal	DAHS/NF p.m. Snack	NF Evening Meal	NF Evening Snack	Total
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 Kitchen	NF Breakfast	DAHS/NF Noon Meal	DAHS/NF p.m. Snack	NF Evening Meal	Total Evening Snack	
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 ach 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.

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 Cost Report $54,701.00

NF To be reported on NF Cost 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	Light Trucks & Vans	5 yrs
Building Additions	30 yrs	Buses and Airplanes	7 yrs
Cars and Minivans	3 yrs	Used Vehicles	see 1 TAC Section 355.103(b)(10)(C)(ii)

Asset	Years	Asset	Years
Air Conditioning-5 tons or more	10	Air Conditioning System - Less than 5 tons	5
Apnea Monitor	7	Bath - Whirlpool	10
Bed - Flotation Therapy	10	Bed - Electric	12
Bed - Manual	15	Beepers - Paging	3
Bench - Metal or Wood	15	Bookcase - Metal or Wood	20
Breathing Unit - Positive Pressure	8	Cabinet	15
Camera - Video Tape	5	Cart	10
Chair - Geriatric	10	Chair - Guest	15
Chair - Shower/Bath	10	Chart Rack	20
Computer - Laptop	3	Computer - Personal	3
Computer - Printer	5	Computer - Software	3
Cooler - walk-in	15	Curtains and Drapes	5
Desk - Metal or Wood	20	Dishwasher	10
Dresser	15	Dryer - Clothes	10
Emergency Generator	20	Fax Machine	3
Fencing - Brick or Stone	25	Fencing - Chain Link	15
Fencing - Wood	8	Files - Regular	15

Flooring - Carpet	5	Flooring - Ceramic	20
Flooring - Vinyl	10	Food Service Furniture	15
Guard Rails	15	Housekeeping Furniture	15
Intercom System	10	Landscaping	10
Lawn and Patio Furniture	5	Nurse Call System	10
Nurses' Counter - Built In	15	Nursing Service Furniture	15
Oxygen Tank, Motor, and Truck	8	Parking Lot Striping	2
Paving - Asphalt	8	Paving – Concrete	15
Photocopier - Large	5	Photocopier - Small	3
Pump - Infusion	10	Railings - Handrails (interior)	15
Refrigerator - Commercial	10	Scale	10
Shrubs and Lawns	5	Sofa	12
Table - Food Prep	15	Table - Overbed	15
Table - Wood	15	Telephone System	10
Television	5	Ventilator/Respiratory	10
VCR	5	Washing Machine - Linen, Large	15
Wheelchair	5	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 and is 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 risk shifting to the unrelated party, even if limited to 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 risks 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 Section 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 the 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 an 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 F - Importing Data Into STAIRS

For a smaller provider, the ability of STAIRS to maintain data from year to year will be a positive and time-saving process. It is also possible to import large quantities of asset data into STAIRS. To do so requires that the instructions to prepare a file for upload to be followed exactly. If the data to be imported is not correctly formatted, it will not import correctly, and the system will be unable to utilize the data.

All instructions for importing depreciable assets are found in a Word document at the bottom right of every page in STAIRS. The document is titled "Asset Import Instructions".

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 cost report and properly cross-referenced: submission of the lease agreement with a prior year's cost report does not exempt a facility from the requirement to submit a copy of the agreement with the current cost 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 cost report, please provide a written explanation for the difference.

Item 1 (Type of Ownership of Lessor Entity): If your lessor entity's ownership type 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 contact person's name, title, and phone and fax number with the lessor entity.

Item 4 (Lessor Entity Owners): This year, in addition to name and title, you 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 the instructions above for Schedule D1. It is not required to submit a copy of the central office/shared administration building lease with the cost report Schedules and attachments 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 cost report and properly cross-referenced: submission of the agreement with a prior year's cost report does not exempt a facility from the requirement to submit a copy of the management agreement with the current cost report Schedules and attachments. All interested parties must sign the management agreement and include all sections and attachments. If there is no written management agreement, attach and cross-reference a written explanation for 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. The costs are separately reported by cost category, as 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

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 all residents for the same service. 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, this cost report may include 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. Costs incurred and revenues accrued for providing ancillary services to **Non-Medicaid** residents are unallowable and **must not** be included in 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 a building or departmental equipment expenses. Ancillary building and departmental equipment expenses associated with entities other than the nursing facility should be removed from the cost 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 cost report items.

Therapy services provided by the 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, 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 the 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 which 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 all residents for the same service. 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, fewer 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 include the costs of parenteral and enteral nutritional products. Do not include the costs of specialized staff related to the delivery of these products to the resident; those costs should be reported in Row 10. Ensure 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, 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 accouterments 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 a 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 costs less than $5,000 or has a useful life of less than one year, whereas depreciable equipment is equipment that costs $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 contract the provider’s fiscal year 2020, 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, 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, this cost report may include only appropriately allocated ancillary indirect expenses related to the provision of ancillary services for Medicaid-Only residents. 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**.