2024 Accountability Report Instructions for Nursing Facility (NF)

Provider Finance Department, Long-Term Services and Supports

Texas Health and Human Services Commission (HHSC)

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Contact Information for Assistance

Center for Information and Training (CIT)

- Cost or Accountability Report Completion
- Report Edit
- Cost Report Training
- Instructions

Email: PFD-LTSS@hhs.texas.gov
Phone: 737-867-7817

Cost Information

- STAIRS
- Receipt of Report
- Report Groups Assigned to Combined Entity
- Report Preparers

Email: CostInformationPFD@hhs.texas.gov
Phone: 737-867-7812

State of Texas Automated Information Reporting System (STAIRS)

- Adding Contracts
- Issues with Report Login

Email: info@fairbanksllc.com
Phone: 877-354-3831

Purpose

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

Who Must Complete this Report?

Providers that have received a Final Obligation Letter from HHCS PFD to submit a 2024 Report. Examples would be for a terminating contract or a provider exiting the Rate Enhancement program. 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.

Providers with multiple contracts must file cost reports according to the assigned Cost Report Group.

Excusals

Providers may receive an excusal 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;
- 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 that the provider is required to include in the cost report have been terminated before the cost report due date; or
- If the total number of days 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.

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

Cost Report Training

All HHSC PFD-sponsored cost report training will be offered via webinar. Each webinar will include:

- How to enter a report into STAIRS for the Cost Report Training you are registered for.

Upon completion of the appropriate webinar, preparers will be given the appropriate credit to be qualified to submit a Report. Attendees of a Cost Report Training webinar will not receive a certificate; 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.

To submit a 2024 Accontability Report, a preparer must attend the 2023 or 2024 Cost Report Training webinar. Preparers without the proper training credit will not be able to access the STAIRS data entry application.

What's New for the 2024 Accountability Report

Step 6 - Wages & Compensation

- Step 6.a. General Information
  - Added a question regarding whether the provider is a large employer for the Affordable Care Act.
  - Is it now required to upload Timesheets or Time Studies.

STAIRS

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

It is *crucial* that the preparer read these instructions carefully.

Login IDs and passwords do not change from year to year. The provider's designated Primary Entity Contact can access STAIRS via the links in the email with their login ID and password. If the provider is new, the provider's Primary Entity Contact should receive an email with their login information. If the provider's Primary Entity Contact has not received an email with their login information, they must 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 email notifying them of their login ID and password for STAIRS.

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 Report.

To ensure reliable and accurate reporting, supporting documentation should preferably be system-generated and include the following information in a spreadsheet format:

- Provider Name
- Accounting Basis
- Report Date Range
- Detail Account Descriptions
- Vendor Names
- Amounts

Regardless of whether the supporting documentation is system-generated, it must always be in a spreadsheet format (i.e., Excel). **PDFs and images are not acceptable forms of documentation.**

When submitting payroll records, ensure both hours *and* wages (including taxes and benefits) are included.

Supporting documents for local or federal grants.

HHSC acknowledges providers may be required to submit reports to local or federal jurisdictions based on funds received, upon request. Do not provide HHSC with a copy of these reports and/or any applicable support documentation for these reports unless specifically requested by HHSC.

General

The following rules and instructions govern this cost report:

- Cost Determination Process rules at Title 1 of the Texas Administrative Code (TAC) Sections 355.101-355.111;
- NF program-specific rules at 1 TAC Section 355.306-355.308 and 355.403;
- The Instructions for report completion located on the PFD website; and
- The 2024 general and program-specific Cost Report training materials located on the PFD website.

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

To properly complete this cost report, the preparer must:

- Read and follow these instructions.
- Review the provider's most recently audited cost report and audit adjustment information.
  - The most recently received adjustments are likely those for the 2021 Cost Report (if adjustment information has not been received, email PFD-LTSS@hhs.texas.gov).
  - Preparers must attend and receive credit for an HHSC PFD-sponsored Cost Report Training webinar. Preparers without the proper credit will not be able to access the STAIRS data entry application.
- Create a comprehensive reconciliation worksheet to serve as a crosswalk between the facility and 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.

Due Date and Submission

The report is due to HHSC PFD by the due date listed in the Final Obligation notification.

All attachments and signed and notarized certification pages must be uploaded into STAIRS. Reports will not be considered “received” until the online report has been finalized and all required supporting documents are uploaded. See Appendix A. Uploading Documents into STAIRS. Documentation mailed rather than uploaded into the system will not be accepted. Refer to 1 TAC Section 355.105(c).

Reporting Period

The reporting period is generally the period of the contracted provider's 2024 fiscal year during which its contract was in effect. The reporting period must not exceed 12 months. The beginning and ending dates are pre-populated. If a provider believes the pre-populated dates are incorrect, please email CostInformationPFD@hhs.texas.gov before continuing with cost report preparation. Refer to the Instructions, Step 2, for additional assistance.

Website

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.

Failure to File an Acceptable Cost Report

Failure to file a cost report completed according to applicable 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 appeal processes are specified in 1 TAC Sections 355.111 and 355.105(b)(4)(C).

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 planning and organization would not have been of any assistance. HHSC PFD must receive requests for extensions before the cost report's due date. The provider (owner or authorized signor) must send the extension request to CostInformation.PFD@hhs.texas.gov. The extension request must clearly explain the necessity for the extension and specify the requested extension due date. 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 appeal processes are specified in 1 TAC Sections 355.111 and 355.105(c)(3).

Standards for an Acceptable Cost Report

Accurate Cost Reporting

1 TAC Section 355.102(c) states:

- Accurate cost reporting is the responsibility of the contracted provider. The contracted provider is responsible for including in the cost report all costs incurred, based on an accrual method of accounting, which are reasonable and necessary…in an effort to collect reliable, accurate, and verifiable financial and statistical data, HHSC is responsible for providing cost report training, general and/or specific cost report instructions, and technical assistance to providers.

To be acceptable, a cost report must:

- Be completed following the Cost Determination Process Rules, program-specific rules, cost report instructions, and policy clarifications;
- Be completed for the correct cost-reporting period;

> **Please Note**: The cost-reporting period has been prepopulated. See Step 4. If a provider believes the dates are incorrect, contact HHSC PFD at costinformationPFD@hhs.texas.gov for assistance.

- Be completed using an accrual method of accounting (except for governmental entities operating on a cash or modified accrual basis);
- Be submitted online as a 2024 Cost Report for the correct program through STAIRS;
- Include any necessary supporting documentation, as required, uploaded into STAIRS;
- Include signed, notarized, original certification pages (Cost Report Certification and Methodology Certification) scanned and uploaded into STAIRS;
- There is another option to submit the certification pages with a Digital Signature. Instructions can be found at https://pfd.hhs.texas.gov/provider-finance-department-digital-signature-policy;

- Calculate all allocation percentages to at least two decimal places (i.e., 25.75%);
- If allocated costs are reported, include acceptable allocation summaries and upload them into STAIRS.
- Have uploaded in STAIRS a detailed asset listing/depreciation schedule if the summary method of reporting was used in **Step 8.e.**
- Have uploaded in STAIRS a work paper supporting related party building rent/lease if the summary method of reporting was used in **Step 8.e.**

> **Note**: All uploaded documentation must be in spreadsheet format and preferably system-generated.

Return of Unacceptable Cost Reports

Failure to complete accountability reports according to instructions and rules constitutes an administrative contract violation. In the case of an administrative contract violation, 1 TAC Section 355.111 specifies procedural guidelines and informal reconsideration and appeal processes. Accountability reports not completed according to applicable rules and instructions will be returned for correction and resubmission. The return of the accountability report will consist of un-certifying the file originally submitted via STAIRS, which will reopen the accountability report to allow additional work and resubmission by the contracted provider. HHSC will send notification of the return via email and certified mail. HHSC grants the provider a compliance period of no more than 15 calendar days to correct the contract violation. Failure to resubmit an **acceptable** corrected accountability report and new certification pages by the due date indicated in the return notification will result in the recommendation of a vendor hold. See 1 TAC Section 355.106(a)-(b)

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. A request received that is not signed by an individual legally responsible for the conduct of the contracted provider, or received after the 60th day, will not be accepted. Failure to submit the requested

amendment to the cost report by the due date is considered a failure to complete a cost report. See 1 TAC Section 355.105(d)(1)(A) for more information.

Accounting Methods

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

Cost Report Certification

Contracted providers must certify the accuracy of the cost report submitted to HHSC PFD. Contracted providers may be liable for civil and criminal penalties if the cost report is not completed according to HHSC PFD requirements or if the information is misrepresented and 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 they are not prepared according to all applicable rules, instructions, and training materials.

There is another option to submit the certification pages with a Digital Signature. Instructions can be found at https://pfd.hhs.texas.gov/provider-finance-department-digital-signature-policy. For more information, See Steps 10 and 11. Preparer Certification and Entity Contact Certification. The information will be in the section, “Digital Signature.”

Reporting Data and 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; 150 hours and 20 minutes would be reported as 150.33 hours.

Direct Costing

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

Certain costs are required to be direct-costed, including:

- Medical, health, and 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).
- Direct care staff (e.g., RNs, licensed vocational nurses [LVNs], medication aides, and certified nurse aides) salaries and contract labor compensation **for NFs *only*** (see Appendix H. Definitions, Direct Care for Nursing Facilities, for detailed instructions on reporting direct care staff time, salaries, and wages).

For all attendant care, NFs, and 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 works for the provider in only one program and one position type, the daily timesheet must document the start time, end time, and total time worked. If the attendant works in different programs or 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.

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." Providers must only report allowable costs on the cost report. Unallowable costs should be excluded from the cost report.

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 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 §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 cost report (1 TAC 355.102[g]). Providers may incur these costs, but these costs cannot be considered as part of HHSC's rate determination processes.

Billable and Non-Billable Costs

Billable costs are costs incurred to provide contracted client services for which a unit of service can be directly billed. These are costs often incurred through direct interaction with the individual receiving services. HHSC generally defines these billable costs as direct costs. In accordance with 1 TAC Section 355.102(f)(3),

Direct costs are those costs incurred by a provider that are definitely attributable to the operation of providing contracted client services. Direct costs include, but are not limited to, salaries and nonlabor costs necessary for the provision of contracted client care. Whether or not a cost is considered a direct cost depends upon the specific contracted client services covered by the program. In programs in which client meals are covered program services, the salaries of cooks and other food service personnel are direct costs, as are food, nonfood supplies, and other such dietary costs. In programs in which client transportation is a covered program service, the salaries of drivers are direct costs, as are vehicle repairs and maintenance, vehicle insurance and depreciation, and other such client transportation costs.

Assuming the billable costs meet the test of reasonableness, direct costs are necessary for the provision of client care and are, by definition, allowable costs and should be reported on the cost report.

HHSC generally defines non-billable costs as indirect costs. In accordance with 1 TAC Section 355.102(f)(4),

Indirect costs are those costs that benefit, or contribute to, the operation of providing contracted services, other business components, or the overall contracted entity. These costs could include, but are not limited to, administration salaries and nonlabor costs, building costs, insurance expense, and interest expense. Central office or home office administrative expenses are considered indirect costs.

Indirect costs must be both reasonable and necessary in that they support the provision of client care and ensure the health, safety and wellbeing of individuals receiving services. However, they are not directly tied to a delivered service unit.

Activities that are not directly client-facing, but are essential to deliver required services or ensure health and safety, are indirect and often non-billable costs. Nevertheless, these types of costs are allowable and should be reported on the cost report.

Some examples of non-billable but allowable costs include staff training activities necessary for service delivery or ensuring an individual's health and safety. These may occur when the individual receiving services is absent. A case managers activities related to charting or other duties required to maintain his or her license and supporting contracted services are another example. These activities can be considered indirect and non-billable but are still allowable costs and should be reported on the cost report. Other examples of indirect, non-billable costs include, but are not limited to costs such as telecommunications, rent/lease, mortgage, property taxes, office supplies, administration staff wages and benefits, and insurance costs.

Split Payroll Periods

If a payroll period is split and part of the payroll period falls within the cost reporting period and part falls outside the cost reporting period, the provider has the option of direct costing or allocating the hours and salaries associated with the split payroll period. The method chosen must be consistently applied to 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 allocation methods and consistently use their 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 another department, program, or governmental entity (including Medicare, another federal funding source, or a state agency) is not automatically approved by

HHSC for cost-reporting purposes. See Appendix B for details on the types of approved allocation methodologies, when each can be used, and how to contact HHSC for approval to use an alternate allocation method 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. Central office functions means that administration 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 the following for each allocation calculation:

- A description of the numerator and denominator that is clear and understandable in words and numbers.
- The resulting percentage to at least two decimal places.
- A listing of the various cost categories to be allocated.
- 100 percent of the provider’s expenses by cost category.
- The application of the allocation percentage to each shared cost.
- The resulting allocated amount.
- The cost report item for which each allocated amount is reported.

The numerator and denominator’s description should document the various cost components of each.

For example, the "salaries" allocation method includes salaries/wages and contracted labor (excluding consultants). Therefore, the description of the numerator and the denominator needs to document that both salaries/wages and contracted labor costs were included in the allocation calculations. For the "labor cost" allocation method, the preparer must 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 preparer must 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 preparer must 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., United States Department of Agriculture (USDA), Medicare, U.S. Department of Housing and Urban Development (HUD)), the preparer must provide reconciliation worksheets to HHSC upon request. These reconciliation worksheets must show the following:

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.
3. That the total amount of costs (allowable and unallowable) used for reporting is the same for each report.

Any change in allocation methods from what was 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 allocating 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) for more information.

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, facility leases, organization charts, time studies, functional job descriptions, work papers used in the preparation of the cost report, trial balances, cost allocation spreadsheets, and meeting minutes of the board of directors.

Adequate documentation for seminars and conferences includes a program brochure describing the seminar or a conference program describing the workshop attended. The documentation must provide a description clearly demonstrating that the seminar or workshop provided training on contracted-care-related services or quality assurance. Refer to 1 TAC Sections 355.105(b)(2)(A) and 355.105(b)(2)(B) for more information.

Recordkeeping for Owners and Related Parties

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

- A detailed written description of actual duties, functions, and responsibilities.
- Documentation substantiating that the services performed are not duplicative of services performed by other employees.
- Timesheets or other documentation verifying the hours and days worked.

> **NOTE**: This verification does not mean the number of hours but the actual hours of the day.

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

- Documentation of regular, periodic payments and accruals of the compensation.
- Documentation that the compensation was subject to payroll or self-employment tax.
- A detailed allocation worksheet indicating how the total compensation was allocated across business components receiving the benefit of these duties.

For more information, refer to 1 TAC Section 355.105(b)(2)(B)(xi).

Retention of Records

Each provider must maintain records according to the requirements in 40 TAC Section 49.307 (relating to how long contractors must keep contract-related records). The rule states that records must be kept for at least seven years after all issues that arise from any litigation, claim, negotiation, audit, open records request, administrative review, or other action involving the records are resolved.

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

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

For more information, refer to 1 TAC Section 355.105(b)(2)(A)(ii).

Failure to Maintain Records

Failure to maintain all work papers and 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 appeal processes are specified in 1 TAC Section 355.111 (relating to Administrative Contract Violations). Refer to 1 TAC Section 355.105(b)(2)(A)(iv) for more information.

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 of related-party transactions and other business activities in which the contracted provider is engaged. Failure to allow access to all records necessary to verify information submitted to HHSC PFD on cost reports constitutes an

administrative contract violation. See 1 TAC Section 355.106(f)for more information.

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 PFD Cost Report Review Unit (CRRU) staff. The primary objective of audits and desk reviews is to verify that each provider's cost report:

- Displays financial and other statistical information in the format required by HHSC PFD;
- Reports expenses conforming to HHSC PFD’s lists of allowable and unallowable costs;
- Follows generally accepted accounting principles, except as specified in HHSC’s lists of allowable and unallowable costs and other pertinent rules or as otherwise permitted in the case of governmental entities operating on a cash or modified accrual basis; and
- Is completed according to each program's cost report instructions and rules.

Field audits are conducted consistent with Generally Accepted Government Auditing Standards (GAGAS) promulgated by the U.S. Government Accountability Office. During a field audit or a desk review, the provider must furnish any reasonable documentation requested by HHSC PFD within 10 working days of the request or a later date as specified by HHSC PFD. 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, as per 1 TAC Sections 355.105(b)(2)(B)(xviii), 355.105(f), and 355.106.

For desk reviews and field audits where the relevant records are located outside Texas, the provider’s financial records must be made available to HHSC PFD within 15 working days of field audit or desk review notification. Whenever possible, the provider's records should be made available in Texas. When records are unavailable in Texas, the provider must pay the actual cost for HHSC PFD staff to travel to and review the records located out of state. HHSC PFD must be reimbursed for these costs within 60 days of the request for payment according to 1 TAC Section 355.105(f).

Notification of Exclusions and Adjustments

HHSC PFD notifies the provider by email of any exclusions and adjustments to items on the cost report. See **Steps** 12 and 13. CRRU furnishes providers with written reports of the results of field audits or desk reviews. Refer to 1 TAC Section 355.107 for more information.

Informal Review of Exclusions and Adjustments

A provider who disagrees with HHSC PFD's adjustments has the right to request an informal review. Requests for informal reviews must be:

- Received by HHSC PFD within 30 days of the date on the written notification of adjustments.
- Signed by an individual legally responsible for the conduct of the interested party.
- 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 a denial of the request for informal review. Refer to 1 TAC Section 355.110(c) for more information.

Common Cost Reporting Errors

The following is a list of some 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 is listed, and an organization chart that identifies each owner-employee, related-party employee, or related-party contractor, along with each business entity/component, is not included. Reference Appendix C for more information.
4. Costs are misclassified. For example, the lease expense for a photocopier is incorrectly included in the **Step 8.f**. Operations Supplies line instead of being correctly reported in the Rent/Lease – Departmental Equipment/Other line.
5. Hours and expenses are 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 Expenses rather than Central Office Expenses.
8. A detailed asset listing/depreciation schedule was not uploaded, and the summary method of reporting was used in **Step 8.e**.
9. Ten percent salvage value for a building was not removed in calculating depreciation costs; a summary method of reporting was used in **Step 8.e**.
10. Vehicle depreciable value was not limited to 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. Personal expenses are incorrectly reported 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 are incorrectly reported for relatives or owners who do not work for or perform services for the contract.
4. Unallowable promotional advertising is incorrectly included in reported advertising costs as an allowable cost.
5. Unallowable dues or membership fees to organizations whose primary emphasis is unrelated to contracted services (e.g., the Chamber of Commerce, Lions Club, or Veterans of Foreign War [VFW] organizations) are reported as allowable costs.
6. Unallowable penalties or fines (such as non-sufficient funds [NSF] fees or late payment penalties) are incorrectly reported (with allowable expenses).
7. Bad debts are incorrectly expensed as “Other” costs.
8. Payroll taxes are reported incorrectly (e.g., incorrectly reporting the Federal Insurance Contributions Act (FICA)/Medicare taxes at greater than 7.65 percent of the total reported salaries [excluding central office salaries]).
9. Capital expenditures, such as roofs, air-conditioning systems, vehicles, sidewalks, and parking lot paving, are erroneously expensed (rather than properly depreciated).
10. Related-party transactions, such as the lease of a building or vehicles, are not disclosed.
11. Allocated costs are misstated 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. Depreciation costs are overstated because the land cost was incorrectly included with the historical cost of the building.
13. The building depreciation expense is overstated because the 10 percent salvage value was not removed.

14. The transportation equipment depreciation expense is overstated because the depreciable value of a 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.

Common 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 Nurse's 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**.

11. Blood draws are typically done by direct care workers like nurses or aides. Most facilities do not have enough blood draws to hire fill time phlebotomists. If they are hiring a full time phlebotomist, and that’s all they do, then they would be considered Other Resident Care Staff – Professional. These are staff that perform non-attendant care of non-administrative, indirect care functions.

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

STAIRS 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 box will allow the user to change data previously added to this record.

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

Save: Used to save the current data. This button will save the information in the current location and allow additional add, edit or delete actions.

Save and Return: This saves the current data and returns the user to the prior webpage.

Cancel: This cancels all unsaved information on the current webpage and returns the user to the prior webpage.

Stop Signs: A stop sign appears when an action needs to be taken by the preparer before being able to save information on the current webpage, that an edit must be responded to before the report can be finalized, or a required piece of information is needed on the current webpage.

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

User Interface and Dashboard

Entity List

Dashboard | Cost Reporting | Manage

Reference Materials

John Smith

Edit My Info

Director

123 Main St.
Austin, TX

Phone: 123456789

Your Roles

- 100001001 - CPC
- 100001002 - CPC

Important Information

01/15/2014 For 2012 and prior Texas Cost Report users, please click here

Important Upcoming Dates

Upcoming Training Dates

Register for Cost Report Training (excluding MEI)
Register for MEI Cost Report Training

General Reference Material

- Helpful Information for Contacts and Preparers
- How to Import Depreciable Assets Instructions
- STAIRS - Managing Contacts - Procedures
- Uploading File Instructions
- 2015 STAIRS General Announcement

Program Specific Reference Material

- Program Specific Reference Materials

The Dashboard (above) is the initial webpage a STAIRS user will see upon logging into the system. From there, the user can see and edit personal contact information, including their email, address, and telephone and fax numbers. Important messages, listings of important dates, and upcoming training opportunities are included on the Dashboard page. Training registration can be accessed from this page.

By clicking "Manage" in the top right corner, the user can (depending on his or her permissions) add a contact, attach a person to a role, or assign a preparer. This screen is also where contact information is updated. It is imperative to maintain current contact information to receive necessary automated messages and deadlines regarding reports and contracts.

The "STAIRS - Managing Contacts Procedures" document 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 in the Reference Materials section 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. For example, if the user has access permission for only a single component code and program, Component Code 8zz for HCS/TxHmL, then there will only be one option to click on the initial Cost Reporting page. For another example, if the user has access permission for more than one component code and/or program, Component Code 8zz for HCS/TxHmL and Component Code 8zy for HCS/TxHmL and ICF/IID, then the user will need to choose the component code and report in which they wish to work.

Step 1. Combined Entity Data

Purpose

This section aims to gather contact information so that HHSC PFD can contact the provider, preparer, etc., during the cost report review. Verifying that all contact information is correct is essential to ensure the provider receives all review correspondence. Step 1 fields will either be auto-populated for subsequent reports (from the entity's prior cost or accountability report) or blank (if this report is the first for an entity).

How Does HHSC PFD Use the Information?

HHSC PFD uses this information to obtain documentation to address issues found in the cost report review. We regularly contact preparers and providers.

Please ensure your email address is correct in the "Edit My Info" link found on the Dashboard when first logging into STAIRS to receive notices for:

- Report deadlines;
- Notices of reports not received by the deadline, including vendor hold warnings and notices; and
- Notices of adjustments made to your report since certification and recoupments.

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

1. Combined Entity Identification

Combined Entity Identification

Phone:
Fax:
Street Address:
Mailing Address:
Edit Information

Entity Contact Identification

Name:
Job Title:
Entity Name:
Email:
Phone:
Fax:
Mailing Address:
Edit Information

Financial Contact

Name:
Job Title:
Entity Name:
Email:
Phone:
Fax:
Mailing Address:
Edit Information

Report Preparer Identification

Name:
Job Title:
Entity Name:
Email:
Phone:
Fax:
Mailing Address:
Edit Information

Location of Accounting Records that Support this Report

Primary Physical Address:
Edit Information

Save | Save and Return | Cancel

The information is view-only and can only be updated by HHSC Provider Finance Department. Providers and Preparers are required to review the information for accuracy before proceeding. If the information is inaccurate, contact HHSC PFD at CostInformationPFD@hhs.texas.gov to request change.

The provider may update the combined entity's telephone, email, and address information in this section. If this entity is a single provider with no combined entities, this information will be the same for the contracted provider.

Entity Contact Identification

The provider may update the contact person’s information in this section. 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 must be able to answer questions about the contents of the provider’s cost report.

Financial Contact Identification

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

Report Preparer Identification

According to 1 TAC Section 355.102(d), each provider must ensure that each 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 the cost report training (detailed in the next paragraph) from HHSC can complete a cost report in STAIRS. A list of preparers who have completed the training may be accessed through the STAIRS Dashboard.

Preparers must complete cost report training for every program for which a cost report is submitted. Training is required every other year for the preparer to be qualified to complete both the odd-year cost report and the following even-year cost report.

Cost and accountability report preparers may be provider employees or persons contracted by the provider for cost and accountability report preparation. Outside preparers may not be listed as either Entity or Financial Contacts. **NO EXCEPTIONS** 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 address should be where a field audit of these records can be conducted. These records do not refer solely to the work papers used by the provider's Certified Public Accountant (CPA) or other outside preparer. All working papers used in the preparation of the cost report must be maintained according to 1 TAC Section 355.105(b)(2)(i). See also the Recordkeeping section of the General Instructions.

Step 2. General Information

Purpose

The purpose of this step is to:

- Provide general information, including the combined entity's reporting period.
- Determine if the combined entity wants to aggregate reporting expenses used to determine compliance in the Rate Enhancement program.

How does HHSC PFD Use this Information?

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

Aggregating Reports’ Expenses

Aggregating reports’ expenses is combining expenses from multiple reports of the same program to determine the combined entity’s compliance with the Rate Enhancement program.

How Do You Know If You Should Aggregate?

You must have two or more reports in the same cost-reporting entity;

- You must have two or more contracts in the same program;
- All contracts within the same entity and program are participants in Rate Enhancement; and
- You are not terminating your contract. Contracts that are terminating are not eligible for aggregation

How to Complete Step 2

2. General Information

Combined Entity Report Period Beginning (mm/dd/yyyy) *	01/01/2018
Combined Entity Report Period Ending (mm/dd/yyyy) *	12/31/2018

When reporting Facility and Operations expenses would you like to report depreciable assets on step 8e at the summary level? NOTE: By selecting Yes any previous year depreciable asset data will be deleted upon submission of the cost report. *	(•) Yes ( ) No

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

CLASS DSA	
DAHS	
DBMD	
HCS/TxHmL	
ICF/IID	
NF *	Yes
PHC	
RC	

Save | Save and Return | Cancel

Combined Entity Report Period Beginning and Ending Dates

These dates represent the beginning and ending dates for the combined entity’s reporting period. If this entity is a single provider 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 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 December 31 of the cost report year. If these dates are incorrect, contact HHSC PFD at CostInformationPFD@hhs.texas.gov for assistance. Failure to ensure 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 and run through the earlier of the end of the combined entity's fiscal year or the last date on which the combined entity held a contract with HHSC. This date span must match HHSC's records regarding the combined entity's current contract(s) effective dates. If there is a discrepancy, the cost report will be rejected as unacceptable and returned for proper completion.

To change the provider's fiscal year for cost-reporting purposes, the provider must email HHSC PFD at costinformationpfd@hhs.texas.gov. The notification must come from the owner or authorized signatory and 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 IRS approving the change. The provider must state the effective date of the change and the previous corporate fiscal year. HHSC PFD will explain to the provider how to handle each month for cost-reporting purposes since no cost report can cover more than 12 months.

Do You Request to Aggregate by Program Those Contracts Held by this Combined Entity that Participate in the Rate Enhancement Program for the Purpose of Determining Compliance with Spending Requirements?

If an entity operates multiple contracts participating in the Direct Care Staff Rate Enhancement program, the entity may choose to have this group of contracts by program reviewed in the aggregate to determine compliance with spending requirements. If you have only one contract in a particular program or are only submitting one cost report for a program, select "No."

Step 3. Contract Management

Purpose

This step aims to collect information about the combined entity's business components.

- **Step 3.a.** details the combined entity's Medicaid fee-for-service 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 Does HHSC PFD Use this 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 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 component code or all 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 or contract is "No," an explanation must be entered in the Note column.

If the preparer believes additional contracts should be added to the prepopulated list or a component code or 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 the return of all STAIRS cost reports for the combined entity 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 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 webpage, where all the necessary information can be added. See the graphic below. Any changes to this list will trigger changes to the accountability report(s) for any other component code(s) controlled by the provider's combined entity. If another preparer has verified steps involving allocation, completed steps must be verified again. The other preparer must address those steps again before completing those reports.

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

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

	Active Entire Reporting Period	Contract Type	Service Type	Contracting Entity Name	Contract #/ Provider Identification	Added By	Note
	Yes		Hospice		123456	HHSC RAD	
	Yes		Other - provide explanation:Vitamin Shop		35-123456	HHSC RAD	Sells Vitamins to NF
	Yes		Other - provide explanation:DME		1234567	HHSC RAD	Durable Medical Equipment company
	Yes		Other - provide explanation:Market Firm		1234	HHSC RAD	Marketing Firm

Save | Save and Return | Cancel | Add Record | Edit | Delete Record

Information Necessary to Add an Additional Contract Includes:

- Was the contract active during the entire cost report period? – If "No" is chosen, the provider must enter an explanation in the Notes section.
- **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."
- **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 to enter the type of other contract, such as durable medical equipment.
- **Contract # and Provider Identification** – The contract number or other identifying information regarding the contract. For contracts that do not have state or federal contracting numbers, this identifying information 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 it. Then choose either Edit Record or Delete Record.

Step 3.c. Verify Business Component Summary

3.c. Verify 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 webpage lists all cost report groups, grants, and business entities in **Steps 3.a. and 3.b.** above. Preparers must answer the question at the bottom of the page to clear the Stop Sign for this step. The question, "Are there any other contracts, grants, or business relationships 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 prepopulated 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 **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 Does HHSC PFD Use this Information?

HHSC PFD uses this information for various 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 being prepared.

4. General Information

Last Verified by Rate Analysis test on 12/28/2023 7:18 AM

Save | Save and Return | Cancel

Field	Value
National Provider Identifier (NPI) #: Please contact HHSC at costinformationpfd@hhs.texas.gov if the provider believes this is not their current NPI number.	140, 141
Facility Identification #: Please contact HHSC at costinformationpfd@hhs.texas.gov if the provider believes this is not their current facility identification number.	N/A
Type of Ownership of Contracting Entity	**Proprietary (For Profit)**: (selected) 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
Contracted Provider Report Period Beginning (mm/dd/yyyy)	08/01/2023
Contracted Provider Report Period Ending (mm/dd/yyyy)	05/01/2024
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?	Yes
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.	Yes 100016-2024-test.txt Select file or upload new file
Does the provider choose to waive the right to mitigation of any recoupment amounts related to failure to meet spending requirements for the reporting period?	Yes
Upload an organizational chart. The organizational chart must include the employee name, position, and any related party information.	100016-2024-test.txt Select file or upload new file
Were there any units of service during this cost reporting period?	Yes

Public Health Emergency Related Questions

Question	Answer
Did the provider experience a change in costs/utilization directly related to a public health crisis that resulted in an issued state or federal emergency declaration (i.e. COVID-19)?	---
Did the provider incur an increase in costs directly related to a public health crisis that resulted in an issued state or federal emergency declaration, (i.e. COVID-19)? For example, some providers may have paid more for Personal Protective Equipment (PPE) – either because they had to purchase.	---
Did the provider incur costs for a category(ies) that historically is not incurred when administrating/delivering this program/service?	---
Did the provider receive local, state, or federal grants directly related to a public health crisis that resulted in an issued state or federal emergency declaration (i.e.COVID-19)?	---

Save | Save and Return | Cancel

National Provider Identifier Number

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

Facility Identification Number

The Facility Identification Number will be prepopulated here. Contact HHSC PFD at CostInformationPFD@hhs.texas.gov if you believe this number is not your current number.

Type of Ownership of Contracting Entity

Identify the type of ownership of the provider contracting entity from the list.

> **Note**: If the provider is a for-profit corporation or one segment of a for-profit corporation (e.g., a DBA of a for-profit corporation), "Corporation" is the appropriate entry.

Contracted Provider Reporting Period Beginning and Ending Dates

These dates represent the beginning and end 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 reporting for the first time this year, the dates are based on the beginning date of the first contract and the assumption that the provider is on a calendar fiscal year, so it has an ending date of December 31 of the cost report year. If these dates are incorrect, contact HHSC PFD for assistance at CostInformationPFD@hhs.texas.gov.

When the cost report group did not have at least one contract active for the provider's entire fiscal year-end, the reporting period must match with HHSC records regarding the effective dates of the provider's current contract(s).

If these dates are incorrect, contact HHSC PFD at CostInformationPFD@hhs.texas.gov for assistance. Failure to ensure 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.

If the provider's reporting period is less than 12 months, the preparer must properly report only those statistics, revenues, and expenses associated with the reporting period. For example, if the reporting period was February-December, it is unacceptable for the preparer to report a percentage of the provider's annual days of service, annual revenues, and annual expenses. Instead, the preparer should report only information related to the reporting period, meaning that units of service, revenues, and costs related to January should not 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, the preparer must report only those statistics (e.g., units of service), revenues, and costs associated with the actual cost-reporting period. If, for example, the provider's cost-reporting period was August 15-December 31, it is unacceptable for the preparer to report a percentage of the

provider’s total days of service, revenues, and costs for the year. Instead, the preparer must report the days of service, revenues, and costs associated only with the period from August 15 through December 31. Since August is partially reported, the preparer will have to calculate a percentage of various costs applicable to August (e.g., building rent/depreciation, utilities, and other such "monthly" costs) and include that with the actual costs for the reporting period. For questions regarding the appropriate method for reporting information for less than a full year, please contact the Provider Finance Customer Information Center at PFD-LTSS@hhs.texas.gov.

Is the Provider a Participant in the Direct Care Staff Rate Enhancement for the Entire Reporting Period for this Cost Report?

This answer will be prepopulated and based on whether the provider participated for the entire cost reporting period. If the prepopulated answer appears incorrect, please contact HHSC PFD at CostInformationPFD@hhs.texas.gov.

Was an Accrual Method of Accounting Used for Reporting all Revenues, Expenses, and Statistical Information on this Report, Except for Where Instructions Require Otherwise?

Click either “Yes” or “No.” If “No,” provide a reason in the Explanation Box. For the definition of the accrual method of accounting, see the Appendix H. 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 Adjustments and Make the Necessary Adjustments When Preparing this Report?

Click either “Yes” or “No.” If “No,” provide a reason in the Explanation Box. Each provider should review the most recent cost report audit results (desk review or field audit) and make any necessary changes to the current cost reports. Refer to 1 TAC Section 355.107 for more information about field audits. If the provider is in

the process of appealing an audit adjustment when the current cost report is submitted, the preparer is still required to make any necessary changes resulting from the prior cost report audit or informal review decision. The provider may explain their disagreement with how a particular cost must be reported because of the previous audit or informal review.

Does the Provider have Workpapers that Clearly Reconcile Between the Fiscal Year Trial Balance and the Amounts Reported on this Report?

Click either "Yes" or "No." If "Yes," 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 workpapers and any additional supporting work papers (e.g., 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 the allocation of costs to all contracts, grants, programs, and business entities. The preparer must attach a reconciliation worksheet to facilitate the audit process, with its foundation being the provider's year-end trial balance. Refer to 1 TAC Section 355.105(b)(2)(A) for more information.

Is the Provider Reporting Central Office Expenses in this Report?

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

Is the Provider Reporting any Allocated Non-Central Office Program Administration Expenses?

Click either "Yes" or "No." If "Yes," 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 Program Administrator time to the program.

Upload an Organizational Chart

The organizational chart must include the number of employees, position titles, and any related party information. Organizational charts should also include sufficient information about any contracts, components, or operations that share costs with the reviewed contract, to assist HHSC in reviewing allocations regardless of whether

the provider has related parties or not. This includes information on Owner-Employee for each business entity or component, Other Related-Party Employee for each business entity or component, and Related-Party Contractor for each business entity or component. See **Appendix C** for an example.

Did the Provider evacuate the 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 the Provider accept evacuees from a natural disaster that resulted in an issued state of federal emergency declaration (i.e., Hurricane) that did not become permanent residents at the 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.

Public Health Emergency Related Questions (COVID-19)

Did the provider experience a change in costs/utilization directly related to a public health emergency that resulted in an issued state or federal emergency declaration (i.e., COVID-19)?

Select Yes or No.

Did the provider incur an increase in costs directly related to a public health crisis that resulted in an issued state or federal emergency declaration? 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.

Select Yes or No. If Yes, two prompts will appear asking if the increase was in unit of service and if the increase was due to an increase in costs per unit of service. If the answer to either of these follow up questions is No, an explanation will be required.

Did the provider incur costs for a category(ies) that historically is not incurred when administrating/delivering this program/service?

Select Yes or No. If Yes, upload the Excel template outlining these costs.

Did the provider receive local, state or federal grants directly related to a public health crisis that resulted in an issued state or federal emergency declaration?

Select Yes or No. If Yes, the following prompt will appear: "How much did the provider use during the reporting period?" Enter the amounts of Local, State, Federal, and Other Funds. Do not include funds received that the provider plans on using outside of the reporting period.

Step 5. Units of Service and Revenue

Purpose

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

How Does HHSC PFD 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 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

Field	Entry
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?

Report whether the number of Medicaid contracted beds on the last day of the reporting period applied to all days of the reporting period. If it was not, check “YES.”

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.”

Total 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.

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 the 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?

Report whether the number of Medicaid contracted beds on the last day of the reporting period applied to all days of the reporting period. If not, check "YES."

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."

Total 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.

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 the resulting number of Medicaid-contracted 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

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 as follows: ((10 x 15) + (13 x 16)) / 31 = 11.54 beds, which should be rounded up to the nearest whole number, equaling 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 units of service, the provider should report paid units for services delivered during the cost-reporting period. Units paid from private (non-Medicaid) payer sources can be reported under private pay units. If a provider has billed additional units that were not paid by fee-for-service Medicaid 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 the appropriate RUG.

5.b. Bed Days

Upload Data From Excel

Download Template File

Choose Upload Cancel

Fee-for-Service Days of Service in Medicaid Contracted Beds			
RUG	Rate Period 2 01/01/2018 - 08/31/2018	Rate Period 3 09/01/2018 - 12/31/2018	Total Days of Service
RUG RAD			0
RUG RAC			0
RUG RAB			0
TOTAL	0	0	0

Non-Medicaid Days of Service in Medicaid Contracted Beds				
Service	Rate Period 2 01/01/2018 - 08/31/2018	Rate Period 3 09/01/2018 - 12/31/2018	Total Days of Service	Revenue
Medicare Residents in Medicaid Contracted Beds			0	
V.A. Residents in Medicaid Contracted Beds			0	
Private Insurance Residents in Medicaid Contracted Beds			0	
Private Residents in Medicaid Contracted Beds			0	
Dual-Eligible Demonstration - Non-Medicaid Days			0	
TOTAL	0	0	0	0

Days of Service in Non-Medicaid Contracted Beds				
Service	Rate Period 2 01/01/2018 - 08/31/2018	Rate Period 3 09/01/2018 - 12/31/2018	Total Days of Service	Revenue
Medicare Residents in Medicare Certified Only Beds			0	
Other Residents in Non-Medicaid Contracted Beds			0	
Dual-Eligible Demonstration - Medicare Days			0	
TOTAL	0	0	0	0

Upload Data From Excel

Download Template File

Choose Upload Cancel

Save Save and Return Cancel

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 break down 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 on an accrual basis, based on the date of service provision and not by the date revenues were received. Bed holds or room holds are not considered units of service.

Report "pending" residents in the category HHSC is most likely to classify them (make an educated guess) until they have been certified and qualified. Days for which residents were charged for "room hold" or "bed hold" are not considered days of service and are not to be counted as resident days. See **Step 5.d.** for more information.

Days of service for HHSC residents under the Respite program should be reported in **Step 5.b.**, Private Residents in Medicaid Contracted Beds, or 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. 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.

Step 5.c. Other Revenues and Applied Income

Other Revenues	
Type	**Revenue**
Room and Bed Holds	
Gifts, Grants, Donations, Endowments and Trusts	
Appropriations from State and Local Government Sources	
Interest - Funded Depreciation Account; Qualified Pension Fund; Debt Service Reserve Fund	
Gain on Sale of Assets	
Other - Excess of Other Revenues Over Direct Expenses	
Total Other Revenues	**0.00**

Other revenues refer to income other than routine operating revenue. 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 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 seperate Medicare routine revenues from Medicare ancillary revenues, report the entire daily payment as Medicare routine revenue.

Note: Routine operating revenues must be reported as the 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 III (RUG-III) 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 in **Step 5.c.** Resident revenue also includes the payment of late fees for accounts paid after the due date.

Provider Relief Funds (PRF) revenue recognized during the cost report as a result of lost revenue should not reduce any expenses included on the unadjusted trial balance before those expenses are 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" in **Step 5.c.** of the cost or accountability report as applicable. It will have no impact on the allowable expenses reported.

Step 5.d. Days of Service Summary

Step 5.d. summarizes the days of service entered in **Steps 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 Does HHSC PFD 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

Does the Provider 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 then proceed with the rest of the questions.

Please Select “Yes” or “No” for the Following Self-Insurance Expenses that are reported on this Cost Report.

If the previous question was answered “Yes,” click on each self-insurance category reported on this cost report.

Total Number of Central Office Staff Employed by the Controlling Entity on the Last Day of the Cost Reporting Period.

Count employees only once. Enter the number of central office staff 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 be reported as central office employees only. Do not include contract labor or consultants.

Total Number of Non-Central Office Staff Employed by the Controlling Entity on the Last Day of the Cost Reporting Period.

Count each employee only once. Enter the number of non-central office staff 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 be reported as central office employees only. Do not include contract labor or consultants.

Does the Provider have any Related-Party Wages and Compensation (Employee or Contractor) Included in the Cost Report?

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

question will populate asking the preparer to certify at this time if they are completely sure there are no related party wages or compensation in this cost report.

Was the Provider Considered an Applicable Large Employer for the Purposes of the Affordable Care Act during the Reporting Period in Step 4?

A large employer is any company or entity that has an average of at least 50 full-time employees (i.e., full-time equivalents or FTE). If "Yes," benefits and insurance must be reported in **Step 6.d**. If "No," benefits and insurance will not be required in 6.d., but an explanation must be provided if they are not entered.

To determine if the provider is considered an applicable large employer, please visit the following link: https://www.irs.gov/affordable-care-act/employers/determining-if-an-employer-is-an-applicable-large-employer.

Upload an Organizational Chart

The organizational chart must include the number of employees, names of employees, position titles, and any related party information. Organizational charts should also include sufficient information about any contracts, components, or operations that share costs with the reviewed contract to assist HHSC in reviewing allocations regardless of whether the provider has related parties or not. This includes information on an Owner-Employee, Other Related-Party Employee, and Related-Party Contractor for each business entity or component. Refer to Appendix C for an example.

Upload Timesheets and/or Time Study Documentation

Per 1 TAC Section 355.102(j), direct costing must be used whenever reasonably possible. Payroll costs (including health insurance premiums, life insurance premiums, and other employee benefits) of a direct care employee who works across cost areas within one contracted program would be directly charged to each cost area of that program based upon that employee's continuous daily time sheets. The costs of a direct care employee who works across more than one service delivery area would also be directly charged to each service delivery area based upon that employee's continuous daily time sheets.

If cost allocation is necessary for cost-reporting purposes, contracted providers must use reasonable methods of allocation and must be consistent in their use of

allocation methods for cost-reporting purposes across all program areas and business entities. Payroll costs for an administrative employee working across business components could be directly charged based upon that employee's time sheets and/or allocated based upon a documented time study.

Refer to the previous sections on Direct Costing, Split Payroll Periods, and Cost Allocation for more information. Refer also to 1 TAC Section 355.102(j).

Daily timesheets documenting time are required for all 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 time, the end time, and the total time worked. If the employee works in different programs or more than one position type, 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.

Owners (who are included in the Executive Administration staff category) and all related parties are subject to specific TAC requirements for time documentation. Per 1 TAC Section 355.105(b)(2)(B)(xi), the documentation should include, for owners and related parties:

- verification of the hours and days worked.
- verification of the amount of total compensation paid for duties, functions, and responsibilities performed, with a breakdown detailing regular salary, overtime, bonuses, benefits, and other payments.
- documentation of regular, periodic payments and/or accruals of the compensation.
- documentation that the compensation is subject to payroll or self-employment taxes.
- a detailed allocation worksheet indicating how the total compensation was allocated across business components receiving the benefit of these duties.

Should the provider choose to include a time study as part of the uploaded documentation, certain rules apply. Per 1 TAC Section 355.105(b)(2)(B)(i): "The minimum allowable statistical duration for a time study upon which to base salary allocations is four weeks per year, with one week being randomly selected from each quarter to assure that the time study is representative of the various cycles of business operations. One week is defined as only those days the contracted provider is in operation for seven continuous days. The time study can be performed for one continuous week during a quarter, or it can be performed over five or seven individual days, whichever is applicable, throughout a quarter. The

time study must be a 100% time study, accounting for 100% of the time paid to the employee, including vacation and sick leave."

Timesheet requirements for direct care staff are detailed further below. The uploaded documentation must include timesheets for all direct care employees reported. Time studies are not an acceptable method for documenting direct care employee costs.

All documentation must be in spreadsheet format and preferably system generated.

Documentation Requirements for all wages, compensation, and benefits

All staff whose duties include multiple direct care services (e.g., direct care workers, direct care trainers, and job coaches) and/or both direct care services and non-direct care services 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 each separate function to be reported in different lines of the cost report. Time must be directly charged, and allocation of time is not acceptable in such situations.

Required documentation of direct care service staff hours and compensation includes, but is not limited to, timesheets (for staff performing more than one function or working for more than one entity), job descriptions, payroll records, and written policies relating to compensation and benefits.

See 1 TAC Sections 355.103(b)(2) and 355.105(b)(2)(xi) for specific information about allowable costs and documentation requirements for related-party wages and compensation.

Staff Recruiting, Retention, and Benefits (Cost Report only)

The information entered in the following **Step 6.a.** tables will allow HHSC PFD to evaluate the difficulties that providers face with staff recruitment and retention, especially for direct care staff, and will help HHSC assess how to help providers alleviate these issues going forward. Please note that the information in the following **Step 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 Information

This section asks the provider to assess whether staff recruiting has become difficult for your agency during the last calendar year compared with prior years. For each of the listed staff position types, choose one of the following 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 Reporting Period End

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

> **Note:** The "TOTAL" number at the bottom of this column needs to match 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 vacant positions on the exact date of 12/31/20XX for each position type.

Number of Staff Who Left

Enter the total number of staff who left (resigned, terminated, etc.) during the first half of the year (1/1/20XX-6/30/20XX) and the total number of staff who left during the second half of the year (7/1/20XX-12/31/20XX). This number is also broken down by position type and reporting period by the halfway point.

Reporting Period Start – Reporting Period Halfway Point

Enter the total number of staff during the reporting period indicated up to the reporting period halfway point.

Reporting Period Halfway Point + 1 – Reporting Period End

Enter the total number of staff members during the reporting period indicated up to the reporting period endpoint.

- Less than 6 months – Enter the total number of staff members with less than 6 months.
- Between 6 and 12 months – Enter the total number of staff members between 6 months and 12 months.

Over 12 Months

Enter the total number of staff members over twelve months.

Average Number of Days to Fill Vacant Positions (Estimates Accepted if Unknown)

Enter the average days required to hire new staff to fill a vacant position. Please enter a thoughtful estimate if you do not know the exact number.

Number of Staff Paid Above the Base Wage Rate of $8.00 per Hour on Reporting Period End

Enter the number of staff paid above $8.00 per hour.

Starting Wage for this Type of Position Within Your Agency in 20xx (Hourly Rate)

Enter the average hourly wage for staff starting in each position in your agency for the first time.

Average Hourly Wage for this Type of Position after 2 Years of Employment

Enter the average hourly wage for staff in each position after 2 years of employment with your agency.

Percentage of Work Hours Filled with Overtime or Non-Scheduled Staff (Estimates Accepted if Unknown)

Enter the percentage of staff hours covered by staff working overtime or in a non-scheduled capacity. This category may cover staff vacancies, workload requirements, or other factors. Please enter a thoughtful estimate if you do not know the exact percentage.

Staff Benefits Information

In Addition to Wages, Does Your Agency Provide Benefits to Staff? If, Yes, Check All That Apply.

Click each box to add a checkmark to the benefits your agency offers to full-time and part-time staff. If your agency does not offer a particular benefit to your staff, leave the field blank.

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)	false	false
Dental Insurance (paid in whole or in part by agency)	false	false
Retirement (paid in whole or in part by agency)	false	false
Paid Sick Leave	true	false
Paid Vacation	true	false
Short-Term Disability	false	false
Long-Term Disability	false	false
Jury Duty Leave	true	false
Bereavement Leave	true	false
Vision Insurance	false	false
Employee Assistance Plan	false	false
Life Insurance	false	false

Step 6.b. Related-Party

This step will be disabled, and the preparer will not be able to make entries if "No" was selected to the question regarding Related-Party Wages and Compensation in **Step 6.a.** as listed above. If that question was erroneously answered "No," the preparer must return to that item and change the response to "Yes" to be able to enter data in this step.

6b. Related-Party

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

Save | Save and Return | Cancel | Add Record | Edit | Delete Record

Click "Add record" for Each Owner-Employee, Related-Party Employee, and Related-Party Contract Staff, then enter the following information:

- **First Name**
- **Middle Initial**
- **Last Name**
- **Suffix** – e.g., Jr., III, Sr.
- **Birth Date** – Format as mm/dd (e.g., 10/26 for October 26). The year is not requested.
- **Relationship to Provider** – This relationship 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 a board of directors, membership in a related board of directors, etc.)
- **Percentage Ownership** - (in cases of corporation or partnership)
- **Total Hours Worked** – The total hours worked for all entities within the entire combined entity. If the related party was paid for a "day of service," multiply that day by eight to report hours.
- **Total Compensation** – The total compensation (wages, salary, and 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 amount must be actual compensation without 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 the figure based on Total Compensation divided by Total Hours Worked.

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, the preparer should return to **Step 3.b.** and enter the missing business component data. Allocate or direct cost all hours reported for the individual under Total Hours Worked and Total Compensation to a business component before proceeding. The Hourly Wage Rate will automatically be calculated. If allocated, an allocation method must be chosen, and an allocation summary uploaded when prompted. Follow the instructions below to enter the business component(s).

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

- **Click "Add Record"** – Generates additional lines to record line item information for each business component. Click "Add Record" until all business components allocated to this related party are added.

Enter Line-Item Allocation(s):

- **Hours** – On the gray bar, enter hours allocated or direct costed to each business component. The compensation amount will be automatically calculated.
- **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 attendant definition. See Appendix J. Definitions, Direct Care.
- **Job Title** – Related party's title within the specific business component.
- **Position Type** – Identify the type of position (e.g., central office, management, administrative, direct care, nurse, or direct care supervisory) filled by the related individual.
- **Description of Duties** – Describe the duties performed by the related individual as they relate to the specific cost report. List percentages reflecting how much time the individual is spending on various tasks or performing duties in different reported position types for the individual.
- **Employed or Contracted** – Select either Contracted or Employed. If the related party is compensated during the year both as an employee and as a contractor for the same activity, the contracted hours would have to be entered separately from the employed hours.
- **Total Hours Worked** – Enter hours allocated or direct costed to each area. Allocate or direct cost all hours reported for the individual for the business component to an area before proceeding. Compensation will automatically be calculated.

- **Organizational chart (optional)** – Upload an organizational chart or select from the drop-down menu of documents that have already been uploaded. The organizational chart must include the number of employees, names of employees, position titles, and any related party information. Organizational charts should also include sufficient information about any contracts, components, or operations that share costs with the reviewed contract, to assist HHSC in reviewing allocations regardless of whether the provider has related parties or not. This information includes Owner-Employees for each business entity or component, Other Related Party Employees for each business entity or component, and Related-Party Contractors for each business entity or component. Refer to Appendix C for an example.
- **Line Item Allocation Methodology** – If allocated to multiple line items, an allocation method must be chosen, and an allocation summary uploaded. This summary will only be required if there are multiple line items entered.
- **Business Component Allocation Methodology** – After all business component line item allocations have been completed, reporting a related party in multiple business components will require you to choose a business component allocation method and upload an allocation summary.

Step 6.c. Direct Care Staff

6.c. Direct 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)]
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		

	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)]
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		

	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)
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 **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 Appendix J. 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 Period. This category 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. Even if the salary was paid 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 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.

Employee Benefits/Insurance

For all direct care staff, include 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, or 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-) for more information.

> **Note:** Costs that are not employee benefits, per 1 TAC Section 355.103(b)(1)(A)(iii)(II), include the contracted provider's unrecovered cost of uniforms, staff personal vehicle mileage reimbursement, job-related training reimbursements, and job certification renewal fees. They 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 that case, they are to be reported as salaries and wages. See 1 TAC Section 355.103(b)(1)(A)(iii)(II) 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, 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 direct care staff who transport individuals to and from services and activities of the NF in their personal vehicle unless payroll taxes are withheld on the reimbursements. Reimbursements should be included as salaries and wages of the appropriate staff. Allowable travel and transportation also include mileage and reimbursements of direct care staff who traveled to allowable training in their personal vehicle.

The maximum allowable mileage reimbursement is as follows:

- 1/1/22 – 12/31/22 62.5 cents per mile
- 1/1/23 – 12/31/23 65.5 cents per mile

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):

<u>Columns B-E: Non-Related Party Total Staff Hours, Total Staff Wages, Total Contract Hours, and Total Contract Payment:</u> 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

Note: This section does not apply to the Accountability Report.

Step 7. Payroll Taxes and Workers' Compensation

Purpose

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

How Does HHSC PFD Use this Information?

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

How to Complete Step 7

Report costs for all staff in Step 7:

- Report cost for direct care staff, non-direct care staff/program administration (non-central office), and central office employees separately.
- The payroll tax and Workers' Compensation Insurance (WCI) information reported in Step 7 are accrued on related and non-related-party staff wages reported in the steps below.

If payroll taxes (i.e., 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 salary's allocation method includes both salaries and contract labor.

7. Payroll Taxes and Workers' Compensation

Did the provider have a Section 125 or Cafeteria Plan that covers the employees for insurance premiums, unreimbursed medical expenses and/or dependent care costs?	Yes No
Is your entity a Texas Workforce Commission Reimbursing Employer (e.g., not required to pay quarterly taxes to the Texas Workforce Commission (TWC for unemployment coverage)?	Yes No

Taxes and Workers' Compensation	Direct Care	Other Resident Care and Program Admin	Central Office/ Ancillary Indirect Medicaid -Only	Total
FICA and Medicare Payroll Taxes				0
State and Federal Unemployment Taxes				0
Workers' Compensation Premiums				0
Workers' Compensation Paid Claims				0

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

Click either "Yes" or "No."

Is the entity a Texas Workforce Commission Reimbursing Employer?

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

Taxes

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

FICA & Medicare Payroll Taxes

Report the cost of the employer's portion of these taxes. Do not include the employee's share of the taxes.

The amount reported in Step 7 for FICA & Medicare Payroll Taxes should not exceed 7.65 percent of reported wages, except for the following conditions:

- The provider has indicated that they participate in a Section 125 or Cafeteria Plan that covers the employees for insurance premiums, unreimbursed medical expenses, and dependent care costs.

- The provider has reported staff who are paid more than the FICA Wage Limit of $160,200 for 2023.

State and Federal Unemployment Taxes

Report federal (FUTA) and Texas state (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, you must 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, refunds for prior period overpayments, additional modifiers, surcharges for experiencing high numbers of injuries (such as being placed in a risk pool), and audit adjustments made during the cost-reporting period. The Texas Workers' Compensation Commission audits traditional Workers' Compensation insurance policies yearly, and annual adjustments must be properly applied to the cost reporting period on a cash basis.

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

If the provider's commercially purchased insurance policy does not provide total coverage and has a deductible and coinsurance clause, any deductibles and coinsurance payments made by the employer on behalf of the employee would be considered paid claims (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 number 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 that case, the cost should be reported in Step 6. 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. A cost ceiling must be applied to allowable self-insurance workers’ compensation costs or costs where the provider does not provide total coverage. 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 for more information.

Step 8. Facility & Operations Costs

Purpose

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 does HHSC PFD 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

The information in Step 8.a. will lock or unlock certain sections in Steps 8.b. – 8.e.

8.a. General Information

Question	Options
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 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 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 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.**

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

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," **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 must return to that item and change the response to "Yes" 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 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 for central office costs allocated to the provider containing 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 Appendix H. Definitions, *Related-Party* and *Related-Party Transactions* for more information.

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 certain criteria have been met for each cost report. If all the conditions of this exception are met, the charges by the related-party supplier to the contracted provider fo 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 cost report's due date to be considered for that year's cost report. The provider's request for an exception must demonstrate that all the following criteria have been met:

- The supplying organization is a bona fide separate organization. See 1 TAC Section 355.102(i)(5)(A) for more information.
- Most 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) for more information.
- There is an open, competitive market for the type of services, equipment, facilities, leases, or supplies furnished by the related organization. See Section 355.102(i)(5)(B) for more information.
- The services, equipment, facilities, or supplies are those which commonly are obtained by entities such as the contracted provider from other organizations and are not a basic element of contracted care ordinarily furnished directly to

individuals by such entities. See Section 355.102(i)(5)(C) for more information.

- 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 Section 355.102(i)(5)(D) for more information.

If Medicare has decided that a related-party situation does not exist or has granted an exception to the related-party definition and the provider wants HHSC to accept that determination, the preparer must submit a copy of the applicable Medicare determination with evidence supporting the 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 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) for more information. If HHSC PFD does not receive the request for a related-party exception at least 45 days before the cost report's due date, we are not required to process the request for that cost-reporting year.

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

All purchases and leases of equipment and supplies from a related individual or organization with a value of less than $5,000 and a useful life of less than one year should be included in this step.

- **Click "Add record."**

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

	Name of Related-Party/Organization	Type	Description	Cost to Related-Party	Is Allocation Complete?
					✔

Save | Save and Return | Cancel | Add Record | Edit | Delete Record

- All columns must be completed for each related-party transaction.
- **Name of Related-Party and Organization** – Enter the name of the related-party or organization from whom the contracted provider purchased or leased equipment and 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.

- **Type** –Choose from the drop-down menu. This category is the cost report line item on which the allowable expense will be reported.
- **Description** – Describe the items or goods purchased or leased from the related-party. Examples include purchased office supplies, letterhead, leased or purchased copier or computer (below the depreciable value), etc. The entry of related-party loans, contracted services, and depreciable purchases or leases will be discussed in other steps below.
- **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 supplies that could be purchased or leased elsewhere in an arm's length transaction.

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

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

	Name of Related-Party/Organization	Type	Description	Cost to Related-Party	Is Allocation Complete?

Save | Save and Return | Cancel | Add Record | Edit | Delete Record

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

- **Enter all Cost Area Information.**

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

Name of Related-Party/Organization	Type	Description	Cost to Related-Party

Business Component & Line Item Allocation

Add Record

Cost to Related-Party

Area

Cost to Related-Party

Add Line Item

TOTAL

Select Line Item Allocation Methodology

Attach Methodology

Select file or upload new file

TOTAL

Select Business Component Allocation Methodology

Attach Methodology

Select file or upload new file

Save Cancel

- **Cost to Related-Party** – On the gray bar, enter the cost allocated or direct costed to each business component.
- **Area** – The drop-down 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 be used only 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 Appendix H. Definitions, *Central Office* for more information.
- **Cost to Related-Party** – Enter the cost to the related-party direct costed or allocated to this cost area within the business component.
- **Cost Area Allocation Methodology** – If allocated to multiple cost areas, an allocation method must be chosen and an allocation summary uploaded. This summary will only be required if multiple cost areas are selected.
- **Business Component Allocation Methodology** – After all business component cost area allocations have been completed, the preparer must choose a business component allocation method and upload an allocation summary for an expense allocated to multiple business components.
- **Upload supporting documentation for expenses**. The documentation must include related party transaction records for all related party expenses reported. These transaction records must originate from the related party. Supporting documentation must include the related party, organization name and detail the purpose of each expense.

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. However, it is limited to the interest that would have been charged during the reporting period had the interest rate on the loan been set at the prevailing national average prime interest rate in effect when the loan contract was finalized, as reported by the United States Department of Commerce, Bureau of Economic Analysis, in the Survey of Current Business. The best and quickest source of prime interest rate information is the Federal Reserve Bank of St. Louis website (https://fred.stlouisfed.org/categories/117). This data series extends back to 1949 and is updated monthly.

- **Click "Add record."**

8.c. Related-Party Loans

	Name of Related-Party/Organization	Type	Description	Inception Date	Loan Amount	Term (months)	Interest	Is Allocation Complete?

Save | Save and Return | Cancel | Add Record | Edit | Delete Record

- All columns must be completed for each related individual or organization.
    - **Name of Related-Party Organization** – Enter the name of the related-party or organization from whom the contracted provider purchased or leased equipment and 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.
    - **Description** –Choose from the drop-down menu either Mortgage Interest or Other. This line item is where the allowable cost will appear in the cost report.
    - **Please describe** – If "Other" was chosen for "Description" above, describe the type of loan.
    - **Inception Date** – Month and year the loan was effective.
    - **Loan Amount** – This number should be the total amount of the loan.
    - **Term** – Duration of the loan in months.
    - **Interest** – Allowable interest paid during the reporting period.
- **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, the preparer must 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, the preparer must choose an allocation method and upload an allocation summary.

8.c. Related-Party Loans

	Name of Related-Party/Organization	Type	Description	Inception Date	Loan Amount	Term (months)	Interest	Is Allocation Complete?
								✔

Save | Save and Return | Cancel | Add Record | Edit | Delete Record

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

- **Enter all Cost Area Information**

Business Component & Line Item Allocation

Add Record

Interest

Area | Interest

Add Line Item

TOTAL

Select Line Item Allocation Methodology | Attach Methodology

Select file or upload new file

TOTAL

Select Business Component Allocation Methodology | Attach Methodology

Select file or upload new file

Save | Cancel

- **Interest** – On the gray bar, enter the allowable interest expense allocated or direct costed to each business component.
- **Area** – The drop-down 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 be used only for central office expenses that are allocated between multiple business components. Central office costs that can be directly charged to the contracted provider should be reported as "Program Administration." See Appendix H. Definitions, *Central Office* for more information.

- **Interest** – Enter the allowable interest expense direct costed or allocated to this cost area within the business component.
- **Cost Area Allocation Methodology** – If allocated to multiple cost areas, the preparer must choose an allocation method and upload an allocation summary. This summary will only be required if there are multiple cost areas selected.
- **Business Component Allocation Methodology** – After all business component cost area allocations have been completed, the preparer must choose a business component allocation method and upload an allocation summary for an expense allocated to multiple business components.
- **Upload supporting documentation for expenses**. The documentation must include related party transaction records for all related party expenses reported. These transaction records must originate from the related party. Supporting documentation must include the related party, organization name and detail the purpose of each expense.

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; complete **Step 6.b.** instead. If reporting a related individual as contracted labor who is providing activities typically performed by employee staff (e.g., Attendant and Non-attendant staff services, Program Administration staff services, etc.), complete **Step 6.b**.

> **Note: Step 8.d.** is just for related-party consultants and accountants, not management. Contracted Management should be entered in **Step 8.f**.

- **Click "Add record."**

Save | Save and Return | Cancel | Add Record | Edit | Delete Record

	Name of Related-Party/Organization	Type	Description	Cost to Related-Party	Is Allocation Complete?
No records found.					

Save | Save and Return | Cancel | Add Record | Edit | Delete Record

- **All columns must be completed** for each related individual or organization.
  - **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.
  - **Type** – Choose from the drop-down menu. This line item is where the allowable cost will appear in the cost report.
  - **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.
  - **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.
- **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, 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, the preparer must choose an allocation method and upload an allocation summary.

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

- **Click “Add Record”** – Generates additional lines to record Cost Area information for each business component. Click “Add Record” until all business components to which this expense will be allocated have been added.

  - **Enter all Cost Area Information:**

    ◊ **Cost to Related-Party** – On the gray bar, enter the cost allocated or direct costed to each business component.

    ◊ **Area** – The drop-down 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 central office expenses allocated between multiple business components. Central office costs that can be directly charged to the contracted provider should be reported as “Program Administration.” See Appendix H. Definitions, *Central Office* for more information.

- ◊ **Cost to Related-Party** – Enter the cost to the related-party direct costed or allocated to this cost area within the business component.
- ◊ **Cost Area Allocation Methodology** – If allocated to multiple cost areas, the preparer must choose an allocation method and upload an allocation summary. This summary will only be required if there are multiple cost areas selected.
- ◊ **Business Component Allocation Methodology** – After all business component cost area allocations have been completed, the preparer must choose a business component allocation method and upload an allocation summary for an expense allocated to multiple business components.
- ◊ **Upload supporting documentation for expenses**. The documentation must include related party transaction records for all related party expenses reported. These transaction records must originate from the related party. Supporting documentation must include the related party, organization name and detail the purpose of each expense.

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 must be depreciated if they are valued at $5,000 or more and have an estimated useful life of more than one year at the time of purchase. 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:

- **Depreciation**: Buildings and Building Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, Other Amortization
  - **Buildings and Building Improvements**: Structures (and depreciable improvements to those structures) consisting of a 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 do not include central air conditioning systems and trade fixtures unless they were part of the building when purchased or renovated.
    - ◊ **Structural building improvements (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 percent. 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 component.
    - ◊ **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.
  - **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.
  - **Leasehold Improvements**: Improvements a lessee makes to a leased building. These improvements are permanently attached to the building or land. They become the property of the lessor when the lease is terminated. Examples of leasehold improvements are permanent trade

fixtures, additions, and betterments. All building equipment and land improvements purchased by a lessee and 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.

- **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.
- **Research and Development (R&D), Organizational, and Start-up:** must be amortized over at least 60 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 legal fees, state incorporation fees, stock certificate costs, underwriting costs, and office expenses incident to organizing the company.
  - ◊ Start-up costs include employee training, licensing, utilities, facility cleaning, and other preparations incurred before the first individual (whether Medicaid or non-Medicaid) is admitted to the program. Startup costs do not include capital purchases, which are purchased assets meeting the criteria for depreciation as described in the Cost Determination Process rules.
  - ◊ Any costs that are properly identifiable as capitalizable construction costs must be appropriately classified 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 costs.**

- **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 equipment that are necessary operating assets.

- **Depreciation – Transportation Equipment**: Equipment used to transport individuals in care, staff, or materials and supplies utilized by the provider to provide contracted care. Depreciation expenses for transportation equipment not generally suited or commonly used to transport individuals in care, staff, or provider supplies are unallowable costs. This category 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.
- **Rent/Lease – Building and Building Equipment (for related-party only):** Includes the assets in the previous bullet entitled, "Depreciation: Buildings and Building Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, Other Amortization" that are rented or leased from a related-party. Additional expense types for possible building-related costs are optional entries.
  - **Mortgage Interest** – Mortgage interest for the property leased to the contracted provider that was properly accrued and paid by the related-party.
  - **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.
  - **Property Tax** – Property tax payments for the property leased to the contracted provider that were properly accrued and paid by the related-party.
  - **Insurance Expense** – Insurance expenses for the property leased to the contracted provider that were properly accrued and paid by the related-party.
  - **Other Expense** – Other expenses directly related to the property leased to the contracted provider that were properly accrued and paid by the related-party.
- **Rent/Lease – Departmental Equipment (for related-party only):** includes the assets in "Depreciation – Departmental Equipment" above. Additional expense types for possible departmental equipment-related costs are optional entries.
  - **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.

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

- **Rent/Lease – Transportation Equipment (for related-party only):** includes the assets in "Depreciation – Transportation Equipment**"** above. Additional expense types for possible departmental equipment-related costs are optional entries.
  - **Transportation – Maintenance, Repairs, Gas, Oil, Interest, Insurance, Taxes, Other:** Enter here only the Interest, Insurance, 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.
  - **Other Expense** – Other expenses directly related to the property leased to the contracted provider that were properly accrued and paid by the related-party.

> **NOTE:** 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

Phone (Toll-Free)**:**
800-424-4301

Website:
AHA Online Store

Only include assets of the contracted provider or its central office used directly or indirectly in providing 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 (i.e., 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 Section 355.103(b)(10)(A-C).

Providers can report each single capital asset in **Step 8.e.** and allow the system to determine the straight-line depreciation amount applicable to the cost report, **or** report 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 24RCC 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 the 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 D for more information.

- **Click "Add Record"**

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

Field	Entry
Is this a shared asset?	Yes No
Related-Party or Non-Related-Party	Non-Related-Party Related-Party
Asset	---
Code (optional)	
Description of Asset	---
Asset in Service at end of period?	Yes No
Month/Year Placed in Service (mm/yyyy)	
Years of Useful Life	
Historical Costs	
Salvage Value	
Depreciation Basis	
Prior Period Accumulated Depreciation	
Depreciation for Reporting Period	
Total Expense for Reporting Period	

Save Cancel

- **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.
- **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 non-related-party.

> **NOTE** – Only Related-Party leases are reported through the Depreciation webpages. Non-related-party leases are reported in **Step 8.f**.

- **Asset** – This line item is where 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 related-party costs.
- **Code (optional)** – For internal provider use.
- **Description of Asset** – This category 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.

- **Asset in Service at 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.
- **Years of Useful Life** – The time over which the asset must be depreciated. STAIRS populates this based on the Description entered in "Description of Asset" above for all assets except used vehicles. For used vehicles, determine and enter the required useful life. As per 1 TAC 355.103(b)(10)(C)(ii), "The estimated life of a previously owned (used) vehicle is the longer of the number of years remaining in the vehicle's depreciable life or three years."
- **Historical Cost** – The cost of acquiring the asset and preparing it for use. Does not include goodwill or, for buildings, the cost of the land (land is not a depreciable item).
- **Salvage Value** – This amount will be calculated automatically. Salvage value is the asset's estimated residual value for scrap or salvage after its useful life has ended. All buildings must have a minimum salvage value of at least 10 percent of the historical cost for Medicaid cost-reporting purposes. No other salvage values are required.
- **Depreciation Basis** – Calculated figure equal to **Historical Cost** minus **Salvage Value**.
- **Prior Period Accumulated Depreciation** – Calculated figure. Based on the date placed in service and depreciation calculation on the Depreciation Basis from the date placed in service to the beginning date of the cost reporting period.
- **Depreciation for Reporting Period** – Calculated figure. Based on the date placed in service, the beginning date of the cost-reporting period, date entered as Month/Year removed from service, and the remaining useful life.
- **Total Expense for Reporting Period** – Calculated figure. For related-party leases, this category will include costs from Assets, Code, Description of Asset, and Asset in Service above.

- **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, the preparer must return to **Step 3.b.** and enter the missing business component data. Allocate or direct cost 100 percent of the asset costs a business component before proceeding. If allocated, the preparer must choose an allocation method and upload an allocation summary.

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

    ◊ **Click "Add Record"** – Generates additional lines to record cost area information for each business component. Click "Add Record" until all business components to which this expense will be allocated have been added.

    ◊ **Information in the Business Component Gray Bar:**

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

- **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.
- **Month/Year Removed from Service (mm/yyyy)** – If the asset was removed from service for this business component during the current year, enter the month and year the asset was removed from service.
- **Allocation %** – The percentage of the costs allocated to this specific business component.
- **Expense for Reporting Period** – Calculated figure based on the percentage(s) entered.

- **Enter all Cost Area Information**

  - **Area** – The drop-down 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 central office expenses allocated between multiple business components. Central office costs that can be directly charged to the contracted provider should be reported as Program Administration. See Appendix H. Definitions, *Central Office* for more information.
  - **Asset in Service at End of Period?** – The response for the cost area will default to "Yes" if the business component information above states that the asset itself was in service at the end of the period. This entry field allows for the possibility that the asset is taken out of service for a single cost area but not for all. The allocation of an asset may also change throughout a year. This question allows for flexibility in how asset allocation may change throughout a year.

- **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.
- **Month/Year Removed from Service** – If the asset was removed from service for this cost area during the current year, enter the month and year the asset was removed from service.
  - ◊ Month/Year Placed in Service and Removed from Service allow for changes in allocation percentages throughout a year.
  - ◊ By entering an end date where the allocation changes and adding a record with a new "placed in service date" for the new allocation period, the usage changes will be considered in the calculation of the depreciation below.
- **Allocation %** – The percentage of the costs allocated to this specific cost area.
- **Expense for Reporting Period** – Calculated figure based on the percentage(s) entered.
- **Cost Area Allocation Methodology** – If allocated to multiple cost areas, the preparer must choose an allocation method and upload an allocation summary. This summary will only be required if there are multiple cost areas selected.
- **Business Component Allocation Methodology** – After all business component cost area allocations have been completed, the preparer must choose a business component allocation method and upload an allocation summary for an expense allocated to multiple business components.
- **Upload Schedule E form**. The form is available on our website located here.
- **Upload Related-Party Lease Agreement**.
- **Upload supporting documentation for expenses**. The documentation must include related party transaction records for all related party expenses reported. These transaction records must originate from the related party. Supporting documentation must include the related party, organization name and detail the purpose of each expense.

Reporting Capital Assets at the Summary Level

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.

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

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

	Related-Party or Non-Related Party	ExpenseType	Allocated Business Components	Total Expense for the Reporting Period
◉	Non-Related Party	Depreciation - Building & Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, Other Amortization		
○	Non-Related Party	Depreciation - Departmental Equipment		
○	Non-Related Party	Depreciation - Transportation Equipment		
○	Related Party	Depreciation - Building & Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, Other Amortization		
○	Related Party	Depreciation - Departmental Equipment		
○	Related Party	Depreciation - Transportation Equipment		

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- 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
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- 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.
- 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 webpage has a column for the Line Item Names, three columns for Non-Related Party cost areas, three columns for Related-Party cost areas, a column to total all expenses in each line item, and a column for notes. The three columns for Non-Related and Related-Party cost areas are "Program Administration & Operation" and "Central Office," plus a "Total." Facility and Operations costs should be reported if the provider has a Program Administration office. Even if the building or facility costs are paid by or through a central office, the portion of the building or facility and operations costs directly related to the contracted provider should be reported in the specific cost area as appropriate. The "Program Administration & Operation" 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 webpage 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. In those instances, the cost report will not allow entry in the cost area(s) where that expense may not be reported.

Cost Areas

Program Administration & Operation

The Program Administration & Operation cost area is intended to capture administrative expenses associated with direct program management of the contracted provider itself. These are considered program administrative expenses and should be directly chargeable to the contracted provider. Allocated costs should not be reported in the Program Administration & Operation cost area except for an administrator allocated from the central office.

Central Office

The Central Office cost area is intended to capture the allocated portion of shared (i.e., central office) administrative costs. For example, if documentation supports allowable legal fees directly related to the management of the contracts included in the Cost Report Group, those legal fees should be reported in the Program Administration & Operation cost area. However, the allocated portion would be reported in the Central Office cost area if the allowable legal fees were related to the corporation or related organization (e.g., general employee policies and procedures). If an outside accountant prepared the cost report for the contracted provider, the cost should be directly charged to the Program Administration & Operation 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 included 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 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								

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Depending on the line item type, line items will accept entry into various non-related-party cost areas. Depreciation expenses do 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.

Rent/Lease – Building and Building Equipment

- Report building and building equipment lease/rental costs in this item.
- 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.
- 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).
- Lease deposit payments are not allowable costs at the time of payment. If the total amount of the deposit is not refunded at the time specified in the lease, the amount that was not refunded and used for allowable costs is allowable for cost-reporting purposes at that time. Lease deposits made for remodeling and purchasing replacement items or fixtures are not allowable costs at the time of payment. If the total amount of the deposit is not refunded at the time specified in the lease, the amount that was not refunded and used for allowable remodeling and purchase of replacement items or fixtures is allowable for reporting as repairs, maintenance, or depreciation, whichever is appropriate.
- Lease payments made for goodwill are not allowable costs (see Appendix H. Definitions, *Goodwill* for more information).

Rent/Lease – Departmental Equipment/Other

- Report the lease/rental costs of departmental equipment. Departmental equipment includes telephone systems, pagers, facsimile (fax) machines, photocopiers, and computers.

- If the rental/lease is from a related-party, do not enter directly here. 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).

Interest – Mortgage

- See 1 TAC Section 355.103(b)(11) for more information. Reasonable and necessary interest on current and capital indebtedness is an allowable cost.
- Report the interest expense accrued during the reporting period from purchasing 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 here.
- If a related-party funded the loan, do not enter directly here. Enter through **Step 8.c.**
- Late payment fees and penalties are unallowable costs.
- Interest on vehicle loans should be reported in Transportation – Maintenance, Repairs, Gas, Oil, Interest, Insurance, Taxes, Other below.
- Interest on working capital loans, departmental equipment loans, loans for purchasing building improvements, building renovations, building equipment, and other operational notes should be reported in Interest – Other below.

Insurance – Building and Equipment

- 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).
- 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 liquidate those liabilities. Self-insurance can also be described as 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

allowable insurance costs may also be subject to a cost ceiling. See also 1 TAC Section 355.103(b)(13)(E) and Appendix E for more information.

Taxes – Ad Valorem Real Estate

- Report the cost of ad valorem real estate taxes related to Program Administration and Central Office buildings in this item.
- Tax expenses must be reported on an accrual basis for the cost-reporting period only. If a tax statement covers any period outside the cost-reporting period, the cost must be prorated so the amount on the cost report represents only the cost-reporting period.
  - Report Texas corporate franchise taxes in Taxes – Texas Corporate Franchise Tax below.
  - Report personal property taxes and other operational taxes in Taxes – Other below.

Utilities & Telecommunications

- Biohazard Waste
- Electricity, Gas, Water, Wastewater, Garbage. See 1 TAC Section 355.103(b)(8) for more information. 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.
- Telecommunications utility costs associated with the contracts included in the Cost Report Group are reported here. Telecommunications refers to the cost of internet service, telephone, pager, and facsimile service only and not the cost of purchasing, leasing, or maintaining the associated equipment.

Building/Equipment – Contracted Services, Maintenance, and Repairs

- 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) for more information.
- 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) for more information.

- **Maintenance and Repairs** – Report the applicable amount of building and equipment maintenance and repair expenses related to the contracts included in the Cost Report Group. For cost-reporting purposes, repairs and maintenance expenses are categorized as ordinary or extraordinary repairs. See 1 TAC Section 355.103(b)(9) (A-B) for more information.
  - **Ordinary repairs and maintenance** are defined as outlays for parts, labor, and related supplies necessary to keep an asset operating but neither add materially to the use value of the asset nor prolong its life appreciably. See Section 355.103(b)(9)(A) for more information.
    - ◊ Ordinary repairs include but are not limited to painting, wallpapering, copy machine repair, or repairing an electrical circuit.
  - **Extraordinary or major repairs** involve relatively large expenditures, are not normally recurring, and usually increase an asset's use value or service life 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, replacing a roof, or strengthening the foundation of a building.
    - ◊ Extraordinary repairs that cost $2,500 or more and have a useful life of more than one year may not be reported directly in this item. They must be capitalized and depreciated by reporting in **Step 8.e**. See Section 355.103(b)(9)(B) for more information.

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.

Depreciation – Departmental Equipment

- Enter all departmental equipment costing $5,000 or more and a useful life of more than one year in **Step 8. e**. The calculated depreciation will be transferred here.

Operations Supplies

- For all items of cost, report only net expenses, meaning gross expenses less any purchase discounts, rebates, returns, or allowances.
- **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 and costs related to tuberculosis (TB) tests, chest x-rays, drug tests, and physicals.
- **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 (e.g., nursing, medical records, staff training, and central supply), program administration, and the allocated portion of central office supplies.
    - 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**.
    - Non-depreciable equipment purchased or leased from a related-party may not be reported here directly. Enter it in **Step 8.b**., and the allowable costs will be transferred here.
- Employee benefits not subject to payroll taxes, such as uniforms or non-wage incentives, may be reported here in the appropriate cost area.
- **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.
    - Supplies that are chargeable to Medicare or sources other than Medicaid are not to be included here.
- **Supplies, Office** – Report office supplies in each setting as appropriate.
- **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.

Depreciation – Transportation Equipment

- Enter all transportation equipment costing $5,000 or more and a useful life of more than one year in **Step 8. e**. The calculated depreciation will be

transferred here. The depreciation amount for Luxury Vehicles is $50,203 for 2023.

Rent/Lease – Transportation Equipment or Contracted Transportation Services

- Report transportation equipment lease/rental costs in this item.
- **Non-related-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**.
- **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**.
- **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.

Transportation – Maintenance, Repairs, Gas, Oil, Interest, Insurance, Taxes, Other

- Report transportation expenses related only to the delivery of services. If a vehicle is used for 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 before reporting on the cost report against the cost or group of costs for which the grant was intended. For example, if a grant were received from the Texas Department of Transportation (TX DOT) to assist in purchasing a van, the amount of the grant would be deducted from the cost of the van, and only the remaining cost, if any, would be reported on the cost report as a depreciable asset.
- **Insurance, Vehicle** – Report the cost for insurance premiums or, in cases of self-insurance, allowable paid claims for vehicles. Report only the portion of the insurance expense directly related to the contracts included in the Cost Report Group. See Insurance – Building and Equipment above for details on the proper reporting of Insurance expenses.

- **Interest, Vehicle Loans** – Report the interest from loans for vehicles or repairs/maintenance of vehicles used in the program. If a related-party funded the loan, do not enter directly here. Enter through **Step 8.c**.
- **Property Tax, Vehicles** – Report any property tax paid on vehicles used in the program.
- **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. For cost-reporting purposes, repairs and maintenance expenses are categorized as ordinary or extraordinary repairs.
  - Ordinary transportation equipment repairs and maintenance are defined as outlays for parts, labor, and related supplies necessary to keep an asset operating but neither add materially to the 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.
  - Extraordinary or major vehicle repairs involve relatively large expenditures, are not normally recurring, and usually increase an asset's value or service life beyond what it was before the repair. Extraordinary repairs include such things as engine and transmission overhaul and replacement. Extraordinary repairs that cost $2,500 or more and have a useful life above one year may not be reported directly in this item. They must be capitalized and depreciated by reporting in **Step 8.e**. See Section 355.103(b)(9) (A-B) for more information.
- **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.

Staff Training/Seminars

- To be allowable, the training must be located in Texas (unless unavailable in Texas) and be related directly and primarily to the job performed by the staff person attending the training.

- 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.
- For off-site training, allowable costs include allowable travel costs. See Travel below for more information. Included are registration fees, seminar supplies, and classroom costs that meet the other criteria detailed in 1 TAC Section 355.103(b)(15).
- Training/Seminar costs incurred for Program Administration and Operations and Central Office staff are reported in their respective cost areas.
- Costs for training outside the continental United States are unallowable.

Insurance – Liability

- See 1 TAC Section 355.103(b)(13) for more information.
- Report the cost for insurance premiums for general liability and professional malpractice insurance paid to a nonrelated insurance company in this item, but only in Program Administration and Central Office as appropriate. Also, report the premiums paid to a risk retention group registered with the Texas Department of Insurance.
- Costs related to errors and omissions (liability) insurance for board members are allowable.
- 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**.
- 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. If this arrangement is a self-insurance situation, see Appendix E.

Travel (not to include mileage reimbursement)

- For purposes of training, allowable travel must be within Texas (unless unavailable in Texas), be related directly and primarily to the job 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 to the job performed by the staff person.

- Such travel must be within 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.

- The maximum lodging per diem and meals per diem costs is 150 percent of the General Services Administration's (GSA) federal travel rates to determine the maximum lodging and meals reimbursement rates.
- On this website, select the correct time from the Per Diem Rates, remembering that federal fiscal years begin in October and end in September.
  - For locations not specifically listed on the GSA website, the maximum allowable lodging and meals per diem rates for cost-reporting purposes are based on the Standard rate (listed on the GSA website) multiplied by 1.5, plus any applicable city local/state taxes and energy surcharges.

Fees – Management Contract

- See 1 TAC Sections 355.103(b)(6) and 355.105(b)(2)(B)(xiii) for more information.
- 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 included 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 of **Step 6.a.,** the answer to **"**Question 1. Do you have any contracted management costs to report?" must be "Yes."
- 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 mark-up in the specific items related to the cost and must not be combined into one item.

Fees – Contracted Administrative, Professional, Consulting, and Training Services

- See 1 TAC Section 355.103(b)(3) for more information.
- Report contracted medical records services here.
- Report contracted administrative services, such as clerical temporaries, printing, copying, and courier delivery services here.
- 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)(A) and 355.105(b)(2)(B)(viii) for more information. Professional service fees must be directly related to the provider's activity only and directly or indirectly related to providing services included in the vendor payment.
- **Legal, accounting, and other fees and costs associated with litigation between a provider and a governmental entity are unallowable.** Under 1 TAC Sections 355.103(b)(3)(B) and 355.103(b)(20)(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. Within the narrow range of circumstances where legal expenses are allowable on the cost report, the provider must maintain adequate documentation as described in 1 TAC Section 355.105(b)(2)(B)(viii). Expenses incurred because of imprudent business practices are unallowable.
- Report allowable expenses for workers' compensation administrative and legal expenses here.
- Report allowable franchise fees here. Franchise fees differ from franchise taxes; see Taxes – Texas Corporate Franchise Tax below. Franchise fees that represent goodwill or other intangible services are not allowable. See 1 TAC Section 355.103(b)(20)(C) for more information.
- Report seminar/conference registration fees as training and seminar costs in Staff Training/Seminar above.
- Do not report these unallowable costs on this cost report: NSF charges and other penalties, fees paid to members of the provider's board of directors, and administrative fines and penalties.

Licenses and Permits

- Include fees for licenses and permits and license fees paid on behalf of an employee (e.g., Administrator license).

Interest – Other (describe)

- See 1 TAC Sections 355.103(b)(11) and 355.105(b)(2)(B) for more information.
- 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**.
- The interest expense reported in this item must be offset by any interest income. Only the remaining interest expense, if any, should be reported here.

Taxes – Texas Corporate Franchise Tax

- See 1 TAC Section 355.103(b)(12) for more information.
- 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 time outside the cost-reporting period, the cost must be prorated so 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.

Taxes – Other (describe)

- See 1 TAC Section 355.103(b)(12) for more information.
- Report personal property taxes related to the contents of the Program Administration office building(s) and other operational taxes associated with the Program Administration office building(s) **only**.
- Unallowable taxes include federal, state, and local income taxes; excess profit or surplus revenue-based taxes; taxes levied on assets unrelated to delivering contracted 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.

- Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bonds, property transfers, issuance or transfer of stocks are unallowable as a tax expense; however, such taxes are usually depreciated or amortized.
- Ad Valorem property taxes are reported in Taxes – Ad Valorem Real Estate.
- Texas corporate franchise taxes are reported in Taxes – Texas Corporate Franchise Tax.

Advertising

- See 1 TAC 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.

Dues and Memberships

- See 1 TAC Section 355.103(b)(14) for more information.
- Dues for membership in professional associations directly and primarily concerned with the provision of services for which the provider is contracted are allowable. Any portion of the membership cost applied to lobbying or whose purpose is to fund lawsuits or any legal action against the state or federal government is not allowable.
- Membership dues in purchasing organizations or buying clubs are limited to the prorated amount representing purchases made to provide contracted services.
- Subscriptions to newspapers, journals, and magazines whose content is primarily concerned with providing services for which the provider is contracted are allowable and should be reported in the cost area where the employees' salaries using those subscriptions are reported (i.e., Program Administration and Central Office).
- Dues or contributions to any civic, political, social, fraternal, or charitable organization are unallowable. Chamber of Commerce dues are unallowable.

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. Exceptions include 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).

Consultants (Resident Care)

- 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).

Contracted Services (Resident Care)

- Non-Related Party Contracted Costs for Participants in the Direct Care Staff Compensation Rate Enhancement
- 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.

Supplies (Resident Care)

- Report the costs of nursing and medical supplies, resident care staff in-service training supplies, activities supply, social services supplies, and laundry and housekeeping supplies. Report only net expenses, meaning gross expenses minus any purchase discounts, rebates, returns, or allowances.
- 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. For Medicaid residents, include 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 not to be included in this cost report.

- Medical and nursing supplies that are chargeable to Medicare or sources other than Medicaid are not to be included in 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. These supplies are considered routine items that must be provided to Medicaid residents at no additional charge. Therefore, treat these charges as routine by adding them to the routine revenues reported in the appropriate resident category and associated costs.

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

Off-site Training/Seminars & Travel (Resident Care)

- Report costs incurred for Resident Care Staff while attending training outside the facility. To be authorized, 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)(15). Training/Seminar costs incurred for administrative, maintenance, and other non-resident care staff are to be reported in the training item above as appropriate and are not to be included in this item.

Bio-Hazard Waste Disposal (Resident Care)

- 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 books. This category does not refer to garbage disposal, which is reported in item referencing Utilities and Telecommunications. 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.

Other Resident Care Expenses (Resident Care)

- Do 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 tuberculosis (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 in **Step 6.c.** and **Step 6.d.**
- Do not report Oxygen cost. Oxygen is an ancillary service and must be reported on Schedule G and reported in the Oxygen category.
- Do not include any salaries or wages in this item.
- Do 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. Report costs in Advertising.

Therapy Supplies (Ancillary)

- Include therapy supplies for Physical, Occupational & Speech Therapy.
- Do not include Nutritional Therapy Supplies. Those costs are to be reported in Supplies: Nutritional Therapy Supplies.

Consultants - Physical, Occupational, & Speech Therapy (Ancillary)

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

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

Contract and Off-Site Therapy (Ancillary)

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

Supplies: Nutritional Therapy Supplies, Medical, Nursing, & Incontinent (Ancillary)

- 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 Supplies/Other Dietary Costs.
  - "Ensure" and similar products are not considered ancillary products. The costs of "Ensure," etc., should be reported as Supplies/Other Dietary Costs.

Diagnostic: Laboratory and Radiology (Ancillary)

- 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.

Drugs and Pharmaceuticals (Ancillary)

- Chargeable Drugs and Pharmaceuticals include drugs included or approved for inclusion in the U.S. by Pharmacopoeia, the National Formulary, the U.S.

Homeopathic Pharmacopoeia, or in the American Medical Association (AMA) Drug Evaluations (except for those unfavorably evaluated). 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.

Oxygen (Ancillary)

- 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 associated with delivering oxygen to residents that costs $5,000 or more and has a useful life of more than one year in Step 8e.

DME Purchased by Provider (Ancillary)

- Chargeable Durable Medical Equipment (DME) and Equipment Rental includes medical equipment that 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.

DME Rental/Lease Expense (Ancillary)

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

Contract Dietary Services (Dietary)

- See 1 TAC Section 355.102(f)(3) for more information.
- Report on this item the cost incurred for dietary contract services (other than those for contracted consultant dietitians and nutritionists reported in **Step 6.d.**). Do not include the rental/lease of dietary and kitchen departmental

equipment (e.g., dishwasher, freezer, ice machine, or range). Those costs should be reported in Rent/Lease – Departmental Equipment.

Supplies/Other Dietary Costs (Dietary)

- 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 by subtracting 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 here the nutritional supplements delivered by the total parental nutrition (TPN) systems and enteral nutrition (EN) systems that were reported in Supplies: Nutritional Therapy Supplies, Medical, Nursing, & Incontinent.
- Report expenses for dishes, flatware, utensils, paper products, detergents, reference books, and other resource materials used to plan meals and provide necessary nutritional services.
- Non-depreciable equipment should be reported as supplies in this item for purchases made on or after the beginning date of the provider's fiscal year. Equipment is non-depreciable if it costs less than $5,000 or has a useful life of less than one year.
  - In contrast, equipment is depreciable if it costs $5,000 or more and has a useful life of more than one year.
  - Also, purchases made before the provider's 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: purchases made after the beginning of the contract in the provider's fiscal year of assets 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.
- To determine 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, should be reported in **Step 8.e**. Any repairs and maintenance costs for dietary equipment are reported in Building/Equipment – Contracted Services and Maintenance and Repairs, regardless of the cost of the equipment.
- Examples of costs to be reported in this item include costs related to drug testing, physicals, Hepatitis B vaccinations, TB testing/x-rays, mileage reimbursement, and seminar costs for dietary employees. Rental of dietary equipment should be reported in Rent/Lease.
- Nondepreciable repairs and maintenance costs for departmental dietary equipment should be reported in Operations Supplies. Depreciable repairs and maintenance costs for should be reported in Building/Equipment – Contracted Services and Maintenance and Repairs.

Step 9. Preparer Verification Summary

Purpose

The summary verification webpage shows the Total Reported Revenues and Total Reported Expenses entered into STAIRS. This step allows the provider to reconcile the supporting documentation.

How Does HHSC PFD Use this Information?

This information is for verification purposes only. HHSC PFD 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 webpage shows the total reported revenues and total reported expenses entered into STAIRS. These figures should be checked against the preparer’s supporting documentation to ensure all intended non-HHSC 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 report provides the detail of all units of service and expenses entered. The report can be verified once the preparer has determined everything is entered correctly and all appropriate documentation has been uploaded. 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 PFD. Providers may be liable for civil and criminal penalties if the cost report is not completed according to HHSC requirements or is determined to contain misrepresented or falsified information. Preparers must certify that they read the Cost Determination Process rules, reimbursement methodology rules, cost report cover letter, and cost report instructions and that they understand the cost report must be prepared following the Cost Determination Process rules, 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 Does HHSC PFD Use this Information?

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

How to Complete Steps 10 and 11

Certification pages cannot be printed for signing and notarizing until the report has been verified. If the report is reopened for any reason, any previously uploaded certifications will be invalid and must be completed again. If additional changes need to be made after the report is completed and locked, the preparer must contact CostInformationPFD@hhs.texas.gov to reopen the report(s).

These pages must be maintained in original form by the provider. If these pages are not properly completed, the cost report will not be processed until the provider uploads the completed pages. If the completed pages are not uploaded on time, the cost report will not be counted as received and may be returned. If a report is returnednew certifications are required.

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 prepared the cost report or has primary responsibility for preparing the cost report for the provider. Signing as *Preparer* carries the responsibility for an accurate and complete cost report prepared according to applicable methodology, rules, and instructions. Signing as *Preparer* signifies that the preparer knows the applicable methodology, rules, and instructions and has either completed the cost report himself/herself according to those rules and instructions or has adequately supervised and thoroughly instructed his/her employees in properly completing the cost report. Ultimate responsibility for the cost report lies with the person signing as *Preparer.* If more than one person prepared the cost report, an executed Preparer Certification page (with original signature and original notary stamp/seal) may be submitted by each preparer. All persons signing the methodology certification must have attended the required cost report training.

10. Preparer Certification

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 ________ , ________ .

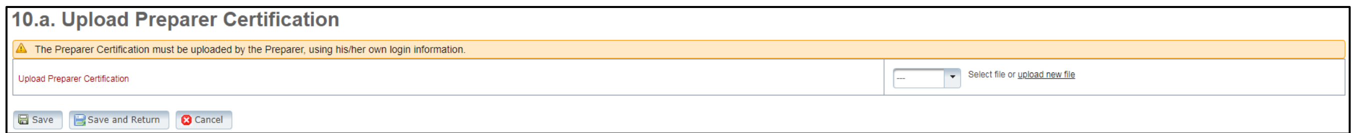
Day *Month* *Year*

______________________________ Notary Signature

______________________________ Notary Public, State of

______________________________ Commission Expires

Return



10.a. Upload Preparer Certification

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

Upload Preparer Certification — Select file or upload new file

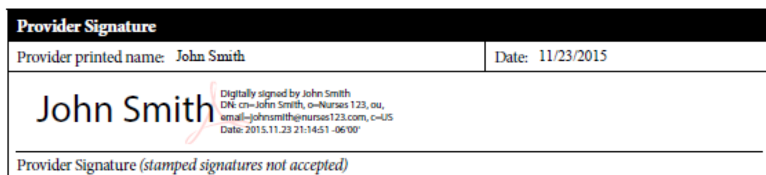
Save | Save and Return | Cancel

Entity Contact Certification

This page must be completed and signed by an individual legally responsible for the provider's conduct, such as an owner, partner, Corporate Officer, Association Officer, Government official, or Limited Liability Company (LLC) 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 (unless using the digital signature option). The signature date must be the same or after the date the preparer signed the Methodology Certification page. The cost report certification indicates the cost report has been reviewed after preparation.

Digital Signatures

According to 1 TAC Section 355.105(b)(4), preparers must certify the accuracy of cost reports submitted to HHSC PFD. This certification must “contain a signed, notarized, original certification page or an electronic equivalent where such equivalents are specifically allowed under HHSC PFD policies and procedures” (1 TAC Section 355.105(b)(4)(ii).



Provider Signature

Provider printed name: John Smith | Date: 11/23/2015

John Smith — Digitally signed by John Smith DN: cn=John Smith, o=Nurses 123, ou, email=johnsmith@nurses123.com, c=US Date: 2015.11.23 21:14:51 -06'00'

Provider Signature *(stamped signatures not accepted)*

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.

HHSC 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.

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

Step 12. Provider Adjustment

Purpose

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

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

How to Complete Step 12

This step will not be visible until the report has been reviewed and the provider is notified of adjustments to or exclusions of information initially submitted. Providers will be notified via email that their adjustment report is ready and have 30 days to review their adjustments. To review, click on Step 12 and review the adjustment report. Once you review Step 12, Step 13 will be available to agree or disagree with the adjustments. After 30 days, the report will be set to "Agreed by Default" status.

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

Expenses

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

Revenues

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

Expenses

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

Revenues

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

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

Summary Table

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

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

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

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

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

Recoupment Summary

Program / Contract / Group	Level Awarded	Spending Requirement	Actual Spending	Per Unit Recoupment	Estimated Total Recoupment
		$0.00	$0.00	$0.00	$100.00
Total Recoupment		$0.00	$0.00	$0.00	$100.00

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. 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 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:

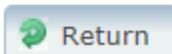
- printed on the contracted provider's letterhead;
- signed by an individual legally responsible for the conduct of the contracted provider, such as the sole proprietor, a partner, a corporate officer, an association officer, a governmental official, or a limited liability company member; and
- scanned 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.



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 Does HHSC PFD 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: Mintonzzz
Job Title: HHSC Admin Account
Entity Name: ZZZ RAD CPC
Email: Pamela.Minton@hhsc.state.tx.us
Phone (123-456-7890): 123456789 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): 79421

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 HHSC PFD has reviewed the report and the provider is notified of adjustments or exclusions of information initially submitted. The step may be completed only 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 by an "Entity Contact" or "Financial Contact" role.

This step must be completed within the 30-day time frame from the date of the email notifying the provider that **Steps 12** and **13** are available for their review.

I Agree

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

Step 13a. I Disagree

13a. Disagree

Please enter and verify the information below

Return | Save and Return

Review Period Expires: June 17, 2022

If you disagree with an adjustment or adjustments made to the Report, you may request an informal review in accordance with Title 1 Texas Administrative Code (TAC) §355.110

The information for the informal review must be uploaded into STAIRS by June 17, 2022 and must contain the following information:
- a concise statement of the specific actions or determinations in dispute;
- the recommended solution;
- any supporting documentation relevant to the dispute.

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

Upload Informal Request for Review Form: Select file or upload new file

A request for an informal review that is not received by this deadline date will not be accepted. If you do not request an informal review by the deadline date you will not be able to request a formal appeal regarding these exclusions or adjustments.

Request Informal Review Extension: I am requesting a 15 calendar day extension of the 30 day deadline to submit an informal review request in accordance with 1 TAC §355.110(c)(1)(A) and as submitted no later than three days before the due date. The extension gives the requestor a total of 45 calendar days to file the informal review request. A request for informal review or extension request that is not received/uploaded by the stated deadline date will not be accepted. Yes No Verify Extension

A provider who disagrees with an adjustment can request an informal review of the adjustments they disagree with. 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 disagreement 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,
- A 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 section is also where you can file for a 15-day extension for the Informal Review.

Step 13b. I Agree and Request a Payment Plan

13b. Agree with Payment Plan

Please enter and verify the information below

Return | Save and Return

Review Period Expires: June 17, 2022

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

- If your recoupment is for a twelve-month period and is greater than $25,000, you may request collection in 3 equal monthly payments.
- If your recoupment is for a twelve-month period and is greater than $75,000, you may request collection in 6 equal monthly payments.

HHSC Provider Finance Department must receive your written request for a payment plan uploaded to STAIRS. A payment plan request must be received no later than the "Review Period Expires" date shown above and below. A payment plan
Payment plan requests received by mail will not be accepted.

Requirements

The request letter must be:
- Printed on the contracted provider's letterhead.
- Payment plan type and length, If applicable.
- 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

Finalized payment plan request uploaded below before the due date listed within this step.

Upload Formal Payment Plan Request Form: --- Select file or upload new file

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 "I Agree and Request a Payment Plan," you can upload the payment plan request. The payment plan request must follow these requirements:

- Must be on the company letterhead.
- Details what is being requested (a payment plan, for example).
- Includes the Cost Report Group number or Contract number of the report.
- Includes the year and type of report (Cost Report 2023, for example).
- 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” (1 TAC Section 355.110(c)(1)(C)).

- Note that the signee is listed on HHSC Form 2031 and is not necessarily the entity contact in STAIRS.

- The request must meet the deadline, which is 30 days from the Provider Notification date.

Step 13.c. Additional Information Requested

Step 13.c. will only appear if you requested an informal review 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.

13c. Additional Information Requested

Please enter and verify the information below

Return Save and Return

Review Period Expires: June 17, 2022

A valid request must contain the following:
- A concise statement of specific actions or determinations made by HHSC since the initial certification of the report. Actions and determinations made by HHSC can be found in

- Recommended resolutions to the disputed actions or determinations.

- Supporting documentation for the recommended resolution requested during the informal review. Documentation includes:
- A trial balance or allocation summary,
- Payroll summary records,
- Legal agreements,
- State or federal awards,
- Grant or obligation letters, or
- Any other documentation that substantiates the requested adjustment.

- The request letter must be signed by an individual legally responsible for the conduct of the entity and submitted by the due date listed within STAIRS.

The reimbursement analyst assigned to your request may include additional information in the text box located within Step 13a.
If you have any questions about what is requested, please contact PFD by email at 'PFD-LTSS@hhs.texas.gov'.

Upload Additional Information: — Select file or upload new file

Step 14. HHSC Informal Review

Purpose

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

How to Complete Step 14

Notes:

General and Statistical

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

Expenses

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

Revenues

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

Revenues

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

Summary Table

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

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

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

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

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

Recoupment Summary

Program / Contract / Group	Level Awarded	Spending Requirement	Actual Spending	Per Unit Recoupment	Estimated Total Recoupment
		$0.00	$0.00	$0.00	$100.00
Total Recoupment		$0.00	$0.00	$0.00	$100.00

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. 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, 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.

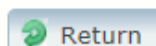
Texas Health and Human Services Commission
Rate Analysis Department, MC H-400
P.O. Box 149030
Austin, TX 78714-9030

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. HHSC PFD uses it to make adjustments during the informal review process. Providers will not be able to access this step until HHSC PFD notifies the provider that adjustments are ready to be viewed.

List of Acronyms

Acronym	Full Name
24RCC	24-hour Residential Child Care
AHA	American Hospital Association
CACFP	Child and Adult Care Food Program
CEU	Continuing Education Units
CFC	Community First Choice
CLASS	Community Living Assistance & Support Services
CMA	Case Management Agency
CPA	Certified Public Accountant
CPC	CLASS and PHC cost report
CPE	Continuing Professional Education
CRRU	Cost Report Review Unit
CRT	Cognitive Rehabilitation Therapy
DAHS	Day Activity and Health Services
DBA	Doing Business As
DSA	Direct Service Agency
EA	Employment Assistance
FICA	Federal Insurance Contributions Act
FUTA	Federal Unemployment Tax Act
GAAP	Generally Accepted Accounting Principles
GAGAS	Generally Accepted Government Auditing Standards
GSA	General Services Administration
HAB	Habilitation
HCS	Home and Community-based Services
HHSC	Texas Health and Human Services Commission
HUD	The Department of Housing and Urban Development
ICF/IID	Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition
IHR	In-Home Respite
IRS	Internal Revenue Service
LLC	Limited Liability Company
LVN	Licensed Vocational Nurse
MDCP	Medically Dependent Children's Program
NF	Nursing Facility
NPI	National Provider Identifier
NSF	Non-Sufficient Funds
OHR	Out-of-Home Respite
OT	Occupational Therapy
PAS	Personal Assistant Services
PCS	Personal Care Services
PFD	Provider Finance Department
PHC	Primary Home Care

Acronym	Full Name
PRF	Provider Relief Funds
PT	Physical Therapy
QMB	Qualified Medicare Beneficiary
R&D	Research and Development
RC	Residential Care
RN	Registered Nurse
SE	Supported Employment
SPW	STAR+PLUS Waiver
ST	Speech/Language Therapy
STAIRS	State of Texas Automated Information Reporting System
SUTA	State Unemployment Tax Act
TAC	Texas Administrative Code
TB	Tuberculosis
TDPS	Texas Department of Public Safety
TMHP	Texas Medicaid and Healthcare Partnership
TX DOT	Texas Department of Transportation
TxHmL	Texas Home Living
USDA	U.S. Department of Agriculture
VFW	Veterans of Foreign War
WCI	Workers' Compensation Insurance

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 355.105(b)(4) and 355.106(a)(4) for more information.

All instructions for uploading documents into STAIRS and managing and attaching those documents electronically can be found in the STAIRS program by clicking on the "Uploading File Instructions" file under "General Reference Materials" at the bottom right-hand corner of any webpage in STAIRS. The Upload Center can be located in STAIRS on the Dashboard by clicking "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 when that is the case. An equivalent unit means the time of service is important: an 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 the activities provided by staff are essentially the same.

Cost-to-Cost: If allocations based on units of service are unacceptable, 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 unacceptable and all of a provider's contracts are labor-intensive, or if all contracts have programmatic or residential building costs, the provider may choose to allocate their indirect shared costs based on salaries. The two cost components of the salary's allocation method:

- Salaries/wages
- Contracted labor (excluding consultants)

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

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

Labor Costs: This allocation method can be used when all of a provider's contracts are labor-intensive; 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 are below:

- 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, with some being labor-intensive and others having a programmatic or residential building component. This method can also be used for an organization with multiple contracts, all requiring a facility for service delivery. This method allocates costs based upon the ratio of each contract's total costs, less that contract's facility or building costs, to the provider's total costs, less facility or building costs for all contracts.

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

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

Functional: If the provider doubts whether the functional method follows applicable rules or requires prior written approval from PFD, email PFD-LTSS@hhs.texas.gov before submitting the cost report.

Time study: The time study must follow 1 TAC Section 355.105(b)(2)(B)(i). If the time study does not comply with these rules, the provider must receive written approval from HHSC PFD to use the time study results. According to the rules, a time study must cover one randomly selected week per quarter, at a minimum, 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(s) approved by HHSC: Requests for approval to change an allocation method or to use an allocation method different from a method approved or allowed by HHSC must be received by HHSC PFD 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, email PFD-LTSS@hhs.texas.gov a disclosure statement and a justification for the change. The statement must explain

how the new allocation method complies 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 PFD. 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 summarizes appropriate allocation methods for various situations. For questions regarding the proper allocation of shared costs, please contact PFD's Customer Service Center 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)	Functional Methods
Allowable Allocation Methods	Units of Service	Cost-to-Cost Labor Costs Salaries	Cost-to-Cost Total-Cost-Less-Facility-Cost^ Labor Costs Salaries	Total-Cost-Less-Facility-Cost^ Labor Costs	Time Study*	Payroll Department - Number of payroll checks issued for each business component during the reporting period Purchasing Department - Number of purchase orders processed during the reporting period for each business component

Providers may use any of the methods listed as appropriate for the makeup of their business organization. If one of the approved methods does not reasonably reflect the provider's actual operations, the provider must use a method that does. If none of the listed methods reasonably reflects the provider's actual operations, contact PFD's Customer Service Center at PFD-LTSS@hhs.texas.gov for further instructions.

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.

Units of Service Allocation

Adjusted Trial Balance – (enter full provider name)

As of (enter begin and end dates)

Expenses	Total Costs	Disallowed	Direct Costs – Austin	Direct Costs – San Antonio	Shared Costs	Allocated Shared Costs – Austin (55.69%)	Allocated Shared Costs – San Antonio (44.31%)
Salaries – Admin	$ 125,347.28				$ 125,347.28	$ 69,805.90	$ 55,541.38
Salaries – Non-Admin A	$ 45,288.47		$25,361.54	$ 19,926.93			
Salaries – Non-Admin B	$ 33,254.88		$25,458.97	$ 7,795.91			
Salaries – Non-Admin C	$ 82,588.92		$51,205.13	$ 31,383.79			
Contracted Admin	$ 65,000.00				$ 65,000.00	$ 36,198.50	$ 28,801.50
FICA/ Medicare	$ 21,915.69		$ 7,804.96	$ 4,521.66	$ 9,589.07	$ 5,340.15	$ 4,248.92
State & Federal Unemployment	$ 5,156.63		$ 1,270.51	$ 554.46	$ 3,331.66	$ 1,855.40	$ 1,476.26
Workers' Compensation	$ 0.00		$ 0.00	$ 0.00			
Employee Benefits/ Insurance	$ 4,847.25		$ 1,254.01	$ 889.47	$ 2,703.77	$ 1,505.73	$ 1,198.04
Office Lease	$ 9,000.00		$ 2,400.00	$ 2,100.00	$ 4,500.00	$ 2,506.05	$ 1,993.95
Utilities	$ 8,945.67		$ 2,385.51	$ 2,087.32	$ 4,472.84	$ 2,490.92	$ 1,981.91
Telecommunications	$ 3,008.16		$ 401.68	$ 333.75	$ 2,272.73	$ 1,265.68	$ 1,007.05
Office Supplies	$ 1,501.80				$ 1,501.80	$ 836.35	$ 665.45
Other Operations Supplies	$ 874.64				$ 874.64	$ 487.09	$ 387.55
Insurance – General Liability	$ 1,254.00				$ 1,254.00	$ 698.35	$ 555.65
Insurance – Malpractice	$ 1,050.87				$ 1,050.87	$ 585.23	$ 465.64

Expenses	Total Costs	Disallowed	Direct Costs – Austin	Direct Costs – San Antonio	Shared Costs	Allocated Shared Costs – Austin (55.69%)	Allocated Shared Costs – San Antonio (44.31%)
Travel	$ 387.98	$ 237.65	$ 54.36	$ 35.74	$ 60.23	$ 33.54	$ 26.69
Advertising	$ 402.87	$ 104.97			$ 297.90	$ 165.90	$ 132.00
Miscellaneous	$ 601.47	$ 254.74			$ 346.73	$ 193.09	$ 153.64
Total	**$410,426.58**	**$ 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
Austin	9,961.00	55.69%
San Antonio	7,924.00	44.31%
Total	**17,885.00**	**100.00%**

Cost-to-Cost Allocation

Adjusted Trial Balance – (enter full provider name)

As of (enter begin and end dates)

Expenses	Total Costs	Disallowed	Direct Costs – Austin	Direct Costs – Houston	Direct Costs – Dallas	Shared Costs	Allocated Shared Costs – Austin (41.48%)	Allocated Shared Costs – Houston (30.72%)	Allocated Shared Costs – Dallas (27.80%)
Salaries – Administrative	$ 125,347.28					$ 125,347.28	$ 51,994.05	$ 38,506.68	$ 34,846.54
Salaries – CBA Attendants	$ 87,434.22		$87,434.22						
Salaries – CLASS Habilita-tion Attendants	$ 65,238.41			$ 65,238.41					
Salaries – PHC Attendants	$ 54,975.15				$ 54,975.15				
Salaries – Supervisors	$ 33,254.88		$13,528.48	$ 9,467.85	$ 10,258.55				
Salaries – Speech Therapists	$ 249.85		$ 249.85						
Salaries – CPR Instructor	$ 2,500.00					$ 2,500.00	$ 1,037.00	$ 768.00	$ 695.00

Expenses	Total Costs	Disallowed	Direct Costs – Austin	Direct Costs – Houston	Direct Costs – Dallas	Shared Costs	Allocated Shared Costs – Austin (41.48%)	Allocated Shared Costs – Houston (30.72%)	Allocated Shared Costs – Dallas (27.80%)
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
State & Federal Unemploy-ment	$ 6,592.50		$ 2,524.07	$ 1,494.13	$ 978.51	$ 1,595.79	$ 661.93	$ 490.23	$ 443.63
Employee Benefits/ Insurance	$ 4,847.25		$ 1,254.01	$ 889.47	$ 1,358.41	$ 1,345.36	$ 558.06	$ 413.29	$ 374.01
Office Lease	$ 9,000.00		$ 2,400.00	$ 2,100.00	$ 2,500.00	$ 2,000.00	$ 829.60	$ 614.40	$ 556.00
Utilities	$ 8,945.67		$ 2,385.51	$ 2,087.32	$ 2,484.91	$ 1,987.93	$ 824.59	$ 610.69	$ 552.64
Telecommu nications	$ 3,008.16		$ 401.68	$ 333.75	$ 554.37	$ 1,718.36	$ 712.78	$ 527.88	$ 477.70
Office Supplies	$ 1,501.80					$ 1,501.80	$ 622.95	$ 461.35	$ 417.50
Medical Supplies	$ 874.64				$ 874.64				
Insurance – General Liability	$ 1,254.00					$ 1,254.00	$ 520.16	$ 385.23	$ 348.61
Insurance – Malpractice	$ 1,050.87					$ 1,050.87	$ 435.90	$ 322.83	$ 292.14
Travel	$ 387.98	$ 204.65	$ 54.36	$ 35.74	$ 84.97	$ 8.26	$ 3.43	$ 2.54	$ 2.30
Advertising	$ 402.87	$ 104.97				$ 297.90	$ 123.57	$ 91.51	$ 82.82
Miscellaneo us	$ 601.47	$ 254.74				$ 346.73	$ 143.82	$ 106.52	$ 96.39

Expenses	Total Costs	Disallowed	Direct Costs – Austin	Direct Costs – Houston	Direct Costs – Dallas	Shared Costs	Allocated Shared Costs – Austin (41.48%)	Allocated Shared Costs – Houston (30.72%)	Allocated Shared Costs – Dallas (27.80%)
Total	**$ 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 Austin	$ 117,955.83	41.48%
Total Healthy Care Houston	$ 87,361.70	30.72%
Total Healthy Care Dallas	$ 79,079.00	27.80%
Total	**$ 284,396.53**	**100.00%**

Salaries Method Allocation

Adjusted Trial Balance – (enter full provider name)

As of (enter begin and end dates)

Expenses	Total Costs	Disallowed	Direct Costs – Austin	Direct Costs – Dallas	Direct Costs – San Antonio	Shared Costs	Allocated Shared Costs – Austin (22.87%)	Allocated Shared Costs – Dallas (50.59%)	Allocated Shared Costs – San Antonio (26.54%)
Salaries – Administrative	$ 125,347.28					$ 125,347.28	$ 28,666.92	$ 63,413.19	$ 33,267.17
Salaries – Attendants	$ 87,434.22		$19,286.35	$ 46,289.32	$ 21,858.55				
Salaries – RNs	$ 44,295.84		$10,352.45	$ 22,576.36	$ 11,367.03				
Salaries – Therapists	$ 54,975.15		$12,094.53	$ 29,136.83	$ 13,743.79				
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
Dietitian	$ 2,400.00					$ 2,400.00	$ 548.88	$ 1,214.16	$ 636.96
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
State & Federal Unemploy-ment	$ 6,592.50		$ 2524.07	$ 1,494.13	$ 978.51	$ 1595.79	$ 364.96	$ 807.31	$ 423.52
Employee Benefits/ Insurance	$ 4,847.25		$ 1,254.01	$ 889.47	$ 1,358.41	$ 1,345.36	$ 307.68	$ 680.62	$ 357.06

Expenses	Total Costs	Disallowed	Direct Costs – Austin	Direct Costs – Dallas	Direct Costs – San Antonio	Shared Costs	Allocated Shared Costs – Austin (22.87%)	Allocated Shared Costs – Dallas (50.59%)	Allocated Shared Costs – San Antonio (26.54%)
Office Lease	$ 9,000.00		$ 2,400.00	$ 2,100.00	$ 2,500.00	$ 2,000.00	$ 457.40	$ 1,011.80	$ 530.80
Utilities	$ 8,945.67		$ 2,385.51	$ 2,087.32	$ 2,484.91	$ 1,987.93	$ 454.64	$ 1,005.69	$ 527.60
Telecommunications	$ 3,008.16		$ 401.68	$ 333.75	$ 554.37	$ 1,718.36	$ 392.99	$ 869.32	$ 456.05
Office Supplies	$ 1,501.80					$ 1,501.80	$ 343.46	$ 759.76	$ 398.58
Medical Supplies	$ 874.64				$ 487.39	$ 387.25	$ 88.56	$ 195.91	$ 102.78
Insurance – General Liability	$ 1,254.00					$ 1,254.00	$ 286.79	$ 634.40	$ 332.81
Insurance – Malpractice	$ 1,050.87					$ 1,050.87	$ 240.33	$ 531.64	$ 278.90
Travel	$ 387.98	$ 204.65	$ 54.36	$ 35.74	$ 84.97	$ 8.26	$ 1.89	$ 4.18	$ 2.19
Advertising	$ 402.87	$ 104.97				$ 297.90	$ 68.13	$ 150.71	$ 79.06
Miscellaneous	$ 601.47	$ 254.74				$ 346.73	$ 79.30	$ 175.41	$ 92.02
Total	**$450,937.82**	**$ 564.36**	**$73,776.60**	**$138,803.15**	**$79,648.99**	**$158,144.72**	**$ 36,167.70**	**$80,005.41**	**$41,971.61**

Salaries Method Allocation Percentages	Total Costs	Percentage
Total Austin	$ 57,033.32	22.87%
Total Dallas	$ 126,147.71	50.59%
Total San Antonio	$ 66,190.94	26.54%
Total	**$ 249,371.97**	**100.00%**

Labor Method Allocation

Adjusted Trial Balance – (enter full provider name)

As of (enter begin and end dates)

Expenses	Total Costs	Disallowed	Direct Costs – CLASS	Direct Costs – PHC	Direct Costs – DAHS	Shared Costs	Allocated Shared Costs – CLASS (41.80%)	Allocated Shared Costs – PHC (21.85%)	Allocated Shared Costs – DAHS (36.35%)
Salaries – Adminis-trative	$ 125,347.28					$ 125,347.28	$ 52,395.16	$ 27,388.38	$ 45,563.74
Salaries – RNs	$ 195,028.62		$87,434.22		$ 65,200.22	$ 42,394.18	$ 17,720.77	$ 9,263.13	$ 15,410.28
Salaries – Field Super-visors	$ 65,238.41			$ 65,238.41					
Salaries – Facility Adminis-trator	$ 54,975.15				$ 54,975.15				
Salaries – Attendants	$ 33,254.88		$13,528.48	$ 9,467.85	$ 10,258.55				
Salaries – Physical Therapists	$ 45,572.08		$45,572.08						
Salaries – CPR Instructor	$ 2,500.00					$ 2,500.00	$ 1,045.00	$ 546.25	$ 908.75
FICA/Medicare	$ 28,018.12		$ 8,073.41	$ 5,715.03	$ 4,990.38	$ 9,239.30	$ 3,862.03	$ 2,018.79	$ 3,358.49

Expenses	Total Costs	Disallowed	Direct Costs – CLASS	Direct Costs – PHC	Direct Costs – DAHS	Shared Costs	Allocated Shared Costs – CLASS (41.80%)	Allocated Shared Costs – PHC (21.85%)	Allocated Shared Costs – DAHS (36.35%)
State & Federal Unemploy-ment	$ 6,592.50		$ 2,524.07	$ 1,494.13	$ 978.51	$ 1,595.79	$ 667.04	$ 348.68	$ 580.07
Employee Benefits/ Insurance	$ 4,847.25		$ 1,254.01	$ 889.47	$ 1,358.41	$ 1,345.36	$ 562.36	$ 293.96	$ 489.04
Workers Compensa-tion	$ 0.00								
Office Lease	$ 9,000.00		$ 2,400.00	$ 2,100.00	$ 2,500.00	$ 2,000.00	$ 836.00	$ 437.00	$ 727.00
Utilities	$ 8,945.67		$ 2,385.51	$ 2,087.32	$ 2,484.91	$ 1,987.93	$ 830.95	$ 434.36	$ 722.61
Telecomm unications	$ 3,008.16		$ 401.68	$ 333.75	$ 554.37	$ 1,718.36	$ 718.27	$ 375.46	$ 624.62
Office Supplies	$ 1,501.80					$ 1,501.80	$ 627.75	$ 328.14	$ 545.90
Medical Supplies	$ 874.64				$ 487.39	$ 387.25	$ 161.87	$ 84.61	$ 140.77
Insurance – Malpract-ice	$ 1,050.87					$ 1,050.87	$ 439.26	$ 229.62	$ 381.99
Travel	$ 387.98	$ 204.65	$ 54.36	$ 35.74	$ 84.97	$ 8.26	$ 3.45	$ 1.80	$ 3.00
Advertising	$ 402.87	$ 104.97				$ 297.90	$ 124.52	$ 65.09	$ 108.29
Miscellan-eous	$ 601.47	$ 254.74				$ 346.73	$ 144.93	$ 75.76	$ 126.04
Total	**$587,147.75**	**$ 564.36**	**$163,627.82**	**$87,361.70**	**$143,872.86**	**$191,721.01**	**$ 80,139.38**	**$41,891.04**	**$69,690.59**

Labor Method Allocation Percentages		Total Costs	Percentage
CLASS	$	158,386.27	41.80%
PHC	$	82,804.89	21.58%
DAHS	$	137,761.22	36.35%
Total	**$**	**378,952.38**	**100.00%**

Total Costs, Less Facility Costs Allocation

Adjusted Trial Balance – (enter full provider name)

As of (enter begin and end dates)

Expenses	Total Costs	Disallowed	Direct Costs – Home Health (PHC)	Direct Costs – Adult Day Care (DAHS)	Shared Costs	Allocated Shared Costs – PHC (57.22%)	Allocated Shared Costs – DAHS (42.78%)
Salaries – Administra-tive	$ 125,347.28				$ 125,347.28	$ 71,723.71	$ 53,623.57
Salaries – PHC Attendants	$ 87,434.22		$ 87,434.22				
Salaries – Adult Day Care Attendants	$ 33,254.88			$ 33,254.88			
Salaries – Adult Day Care Drivers	$ 25,492.12			$ 25,492.12			
Contracted Nurse	$ 9,482.66			$ 9,482.66			
FICA/ Medicare	$ 18,821.78		$ 8,843.84	$ 5,219.57	$ 4,758.37	$ 2,722.74	$ 2,035.63
State & Federal Unemploy-ment	$ 4,428.65		$ 2,822.33	$ 665.10	$ 941.23	$ 538.57	$ 402.66
Employee Benefits/ Insurance	$ 4,847.25		$ 1,254.01	$ 889.47	$ 2,703.77	$ 1,547.10	$ 1,156.67

Expenses	Total Costs	Disallowed	Direct Costs – Home Health (PHC)	Direct Costs – Adult Day Care (DAHS)	Shared Costs	Allocated Shared Costs – PHC (57.22%)	Allocated Shared Costs – DAHS (42.78%)
Office Lease	$ 9,000.00		$ 2,400.00	$ 2,100.00	$ 4,500.00	$ 2,574.90	$ 1,925.10
Utilities	$ 8,945.67		$ 2,385.51	$ 2,087.32	$ 4,472.84	$ 2,559.36	$ 1,913.48
Ad Valorem Taxes	$ 3,256.88		$ 842.64	$ 1,834.64	$ 579.60	$ 331.65	$ 247.95
Maintenance & Repairs	$ 1,846.74		$ 246.25	$ 1,041.67	$ 558.82	$ 319.76	$ 239.06
Telecommun-ications	$ 3,008.16		$ 401.68	$ 333.75	$ 2,272.73	$ 1,300.46	$ 972.27
Office Supplies	$ 1,501.80				$ 1,501.80	$ 859.33	$ 642.47
Medical Supplies	$ 874.64				$ 874.64	$ 500.47	$ 374.17
Insurance – General Liability	$ 1,254.00				$ 1,254.00	$ 717.54	$ 536.46
Insurance – Malpractice	$ 1,050.87				$ 1,050.87	$ 601.31	$ 449.56
Travel	$ 387.98	$ 237.65	$ 54.36	$ 35.74	$ 60.23	$ 34.46	$ 25.77
Advertising	$ 402.87	$ 104.97			$ 297.90	$ 170.46	$ 127.44
Miscellaneous	$ 601.47	$ 254.74			$ 346.73	$ 198.40	$ 148.33
Total	**$ 341,239.93**	**$ 597.36**	**$ 106,684.84**	**$ 82,436.92**	**$ 151,520.81**	**$ 86,700.21**	**$ 64,820.60**

Allocation Percentages	Total Costs	Facility Costs	Total Costs, Less Facility Costs	Percentage
PHC	$ 106,684.84	$ 5,874.40	$ 100,810.44	57.22%
DAHS	$ 82,436.92	$ 7,063.63	$ 75,373.29	42.78%
Total	**$ 189,121.76**	**$ 12,938.03**	**$ 176,183.73**	**100.00%**

Appendix C. Reserved

Appendix D. List of Useful Lives for Depreciation

STAIRS will assign useful lives based on data input in **Step 8.e**. The following minimum depreciation schedules are discussed in 1 TAC Section 355.103(b)(10):

Asset	Depreciation Schedule (Years)
Buildings	30
Building Additions	30
Cars and Minivans	3
Light Trucks & Vans	5
Buses and Airplanes	7
Used Vehicles	See 1 TAC Section 355.103(b)(10)(C)(ii)

Below is an abbreviated list of some useful lives as stated in the AHA's 2018 guide. Refer to the AHA publication for items not listed. The 2018 guide is effective for depreciable assets placed in service during the 2018 and subsequent fiscal years. Depreciable assets placed in service before the 2018 fiscal year should follow the guide in effect at the time.

Table 1. Depreciation Schedule.

Asset	Depreciation Schedule (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

Asset	Depreciation Schedule (Years)
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
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

Asset	Depreciation Schedule (Years)
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 the provider has assumed the risk to protect itself against anticipated liabilities. Self-insurance can also be uninsured. To qualify as an allowable self-insurance plan, a contracted provider must have an agreement with an unrelated party that does not provide for the shifting of risk to the unrelated party designed to provide only administrative services to liquidate those liabilities and manage risks. Such administrative costs are allowable costs that should be reported in **Step 8.f**.

There may be situations in which there is a fine line between self-insurance and purchased or commercial insurance. This gray area is particularly true of “cost-plus” type arrangements. As long as there is at least some shifting of risk to the unrelated party, even if limited to provider bankruptcy or employee termination, the arrangement will not be considered self-insurance. Contributions to a special risk management fund or pool operated by a third party that assumes some risk and has an annual actuarial review are allowable 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 more than costs for similar, comparable coverage by purchased and commercial insurance premiums are subject to a cost ceiling. Documentation substantiating the cost of comparable coverage by purchased and commercial insurance premiums must be obtained and maintained as specified in 1 TAC Section 355.105(b)(2)(B)(ix). Refer to 1 TAC Section 355.103(b)(13)(E) for more information.

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 percent 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 exceeding 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 exceeding the ceiling may be carried forward and expensed in future cost-reporting periods.
   B. If item 1 is less than item 2, add the excess carry-forward amounts from previous reporting periods until the calculated cost ceiling is met.

Documentation Requirements

Maintain documentation that supports the number 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 if commercial insurance for total coverage had been purchased **or** determine the ceiling based on 10 percent 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 the 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. Preparers must follow the instructions to prepare a file for upload exactly to do this. If the data to be imported is not correctly formatted, it will not import correctly, and the system will be unable to use it.

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

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.

> **Note: 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.**

All interested parties must sign the lease agreement 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 of 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 we added space for the contact person's name, title, and phone and fax numbers for 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 everyone 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 8.a.** (Was the nursing facility building leased during the cost-reporting period?) and/or reported a cost on **Step 8.f.** (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 8.f.**, Rent/Lease - Building and Building Equipment, Central Office.

Schedule E: Contract Management Information

If the facility received contracted facility Management Services (as defined in Appendix J, 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.

> **Note:** 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 we added space for the name, title, and phone and fax numbers of a contact person for 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, you are required to provide the percent ownership for everyone 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 6.a.** and/or reported a cost for "Fees - Management Contract" on **Step 8.f.**, 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 8.f**. 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 completing 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 only include 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.

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

Therapy services provided by nursing facility staff only to residents of that nursing facility (not provided to persons outside the facility) are not considered a separate business component but are instead 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, operational costs, and the related central-office costs, do not need to be allocated and removed from the cost report. Report other direct therapy-related expenses according to the instructions for Schedule G.

Therapy services provided from the central office, a separate division or 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. Those costs cannot be directly charged to the nursing facility but must instead be allocated based on the total-cost-less-facility-cost method, the labor method, applicable time studies, or acceptable functional methods. Units of service are 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 and 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 separately identify these costs.

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 only Columns F and G (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 to calculate the portion of their ancillary costs attributable to Medicaid residents. Schedule G is designed based on the Medicare Conditions 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. As a result 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 two 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, minus 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 only Columns F and G,** enter the cost incurred for providing each applicable type of ancillary service to **Medicaid-Only Residents** in Column F. 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) for 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 6.d.** Box 1 in Column G, and $2,000 under **Step 8.f.** Box 3 in Column G.

Row 1-4 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: 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 and physical therapy assistants licensed as physical therapy assistants by the Texas State Board of Physical Therapy Examiners. (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 a license and have accumulated (or are in the process of accumulating) the supervised professional experience (the internship required for license) required for a 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. 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. The costs of Ensure, etc., should be reported as food costs in **Step 8.f.** (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) that 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) that 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. These supplies are considered routine items, so 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.
- Colostomy bags and necessary accessories required for attachment.
- 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. In this situation, enter the cost as a Non-Related Party and include a note in the Notes box indicating it is actually a 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. Report 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, 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, the U.S. Homeopathic Pharmacopoeia, or in AMA Drug Evaluations (except for those unfavorably

evaluated). 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 are documented, there is a physician's order stating the oxygen device and the specific flow rate or concentration of oxygen required, and a periodic assessment of arterial partial pressure of oxygen (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.** and applies to purchases made on or after the beginning date of the provider's 2004 fiscal year. Equipment that costs less than $5,000 or has a useful life of less than one year is non-depreciable equipment, whereas equipment that costs $5,000 or more and has a useful life of more than one year is depreciable equipment. Also, 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, purchases made after the beginning of the contract in the provider's fiscal year 2020 of 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. To determine 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 that 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 that 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.

Use Section 2 of Schedule G for each staff type (i.e., Ancillary Therapists, Ancillary Therapy Assistants, and Other Ancillary Staff) and each type of therapy (e.g., Physical Therapy, Occupational Therapy, Speech Therapy, etc.,), to 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. Sum the values in Row 7, Column C, for each staff type. 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 6.d.** for Ancillary Therapists’ hours, **Step 6.d.** for Ancillary Therapy Assistants’ hours, and **Step 6.d.** for Other Ancillary Staff hours).

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

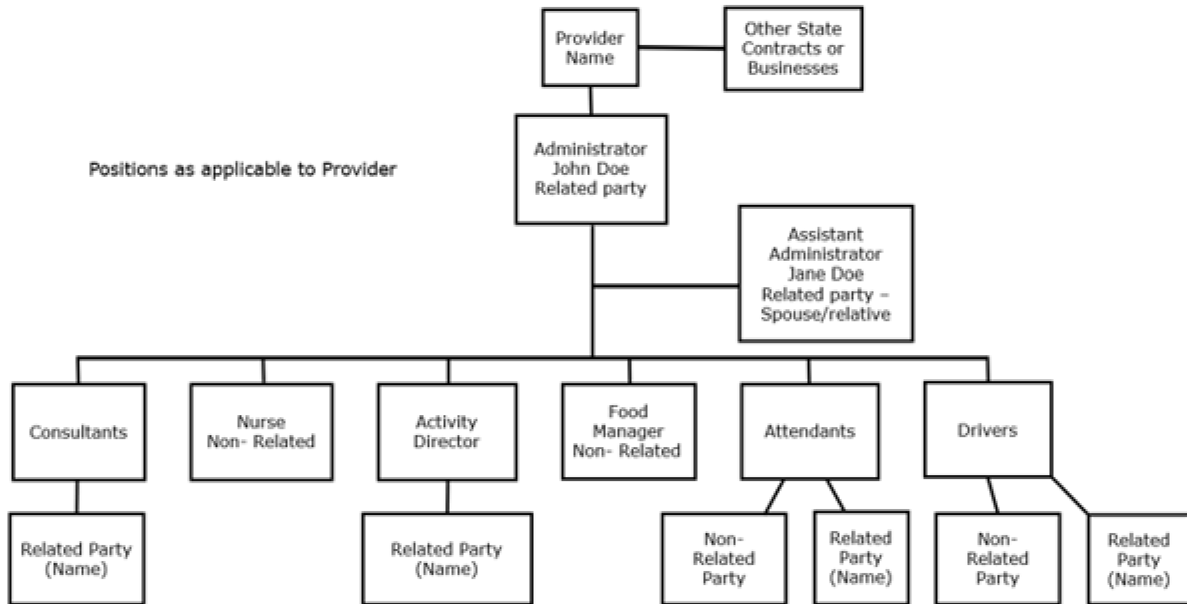
Ancillary indirect expenses are central office expenses (i.e., shared administrative expenses) related to the provision of ancillary services. For Medicaid cost-reporting purposes, this cost report may only include appropriately allocated ancillary indirect expenses related to the provision of ancillary 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, multiply the result by the value in Column B, and 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**.

Appendix H. Trial Balance

	A	B	C	D	E	F	G	H	I
1	Provider Name		Cost Report Number			Period			
2									
3		Trial Balance Or Financial Statement used			Adjustments (as applicable)	To Cost Report			
4									
5	Revenues:		XX.XX						
6	DAHS		XX.XX						
7	MCO Amerigroup		XX.XX			XX.XX			
8	MCO Molina		XX.XX			XX.XX			
9	MCO Superior		XX.XX			XX.XX			
10	Private Pay		XX.XX			XX.XX			
11	Medicare		XX.XX			XX.XX	Depends How cost report is changed.		
12	Veterans Administration		XX.XX			XX.XX	Depends How cost report is changed.		
13									
14									
15	Expenses:								
16	Attendants	XX.XX				XX.XX			
17	Drivers	XX.XX				XX.XX			
18	Employee Benefits-Attendants	XX.XX				XX.XX			
19	RN	XX.XX				XX.XX			
20	LVN	XX.XX				XX.XX			
21	Activity Director	XX.XX				XX.XX			
22	Dietician	XX.XX				XX.XX			
23	Food Service Personnel	XX.XX				XX.XX			
24	Other Permanent Direct Care Staff	XX.XX				XX.XX			
25	Employee Benefits-Non-Attendants	XX.XX				XX.XX			
26	Administrator	XX.XX				XX.XX			
27	Assistant Administrator	XX.XX				XX.XX			
28	Owner	XX.XX				XX.XX			
29	Other administrative Staff	XX.XX				XX.XX			
30	Other Facility & Operations	XX.XX				XX.XX			
31	Employee Benefits - Admin and Op Staff	XX.XX				XX.XX			
32	FICA and Medicare Taxes	XX.XX				XX.XX			
33	Unemployment Taxes	XX.XX				XX.XX			
34	Workers' Compensation Premiums	XX.XX				XX.XX			
35	Workers' Compensation Paid Claims	XX.XX				XX.XX			
36									
37	Rent/Lease - Building and Building Equip	XX.XX				XX.XX			
38	Rent/Lease - Departmental Equipment	XX.XX				XX.XX			
39	Interest - Mortgage	XX.XX				XX.XX			
40	Insurance - Building & Equipment	XX.XX				XX.XX			
41	Taxes - Ad valorem Taxes	XX.XX				XX.XX			
42									
43	Electric & Water	XX.XX							
44	Telephone	XX.XX							
45	Utilities & Telecommunications Subtotal	XX.XX				XX.XX			
46									
47	Building/Equipment-Contracted Services and R&M	XX.XX				XX.XX			
48									
49	Non-Depreciable Equipment	XX.XX							
50	Uniforms	XX.XX							
51	Nursing & Medical Supplies	XX.XX							
52	Office Supplies	XX.XX							
53	Cleaning	XX.XX							
54	Operation Supplies - Subtotal	XX.XX				XX.XX			
63	Staff Training/Seminars-Non Admin Staff	XX.XX				XX.XX			
64	Staff Training/Seminars-Admin	XX.XX				XX.XX			
65	Insurance - Liability	XX.XX				XX.XX			
66	Travel	XX.XX				XX.XX			
67	Fees - Management	XX.XX				XX.XX			
68									
69	Accounting Fees	XX.XX							
70	Payroll Fees	XX.XX							
71	Fees - Contracted - Subtotal	XX.XX				XX.XX			
72									
73	License and Permits	XX.XX				XX.XX			
74	Interest - Other	XX.XX				XX.XX			
75	Taxes - Texas Corporate Franchise Tax	XX.XX				XX.XX			
76	Taxes - Other (Personal Property Tax)	XX.XX				XX.XX			
77	Staff Medical Supplies, Activity Supplies, &	XX.XX				XX.XX			
78	Emergency Personal Care Supplies	XX.XX				XX.XX			
79	Housekeeping	XX.XX				XX.XX			
80	Food, Beverages, and Food Supplies	XX.XX				XX.XX			
81	Contracted Food services	XX.XX				XX.XX			
82	Other Food and food Expenses	XX.XX				XX.XX			
83	Advertising - Public Relations	XX.XX				XX.XX			
84	Advertising - Hiring	XX.XX				XX.XX			
85	Dues and Memberships	XX.XX				XX.XX			
86	Other	XX.XX				XX.XX			

Appendix I. Organizational Chart



Appendix J. 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 at the beginning and end of the reporting period. Amounts earned but not 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 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 under 1 TAC Section 355.105(b)(1). If accrued expenses are not paid within 180 days after the fiscal year-end, and HHSC has not approved a 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 before the end of the 180 days, and the provider later determines that some accrued costs have not been paid within the required 180-day period, the preparer should submit a revised cost report with the unpaid accrued costs removed. See 1 TAC Section 355.105(b)(1) for more information.

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

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

Allowable and Unallowable Costs – "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" (1 TAC Section 355.102(a)). According to 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.
> - 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 fulfilling the purpose for which the business was organized.

Beyond the cost's reasonability, an allowable cost must also be necessary. 1 TAC Section 355.102(f)(2) defines "necessary" below:

> "Necessary" refers to the relationship of the direct or indirect cost incurred by a provider to provide contracted client care. Necessary costs are direct and indirect costs appropriate in developing and maintaining the required standard of operation for providing client care following 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 well-being.
> - the direct or indirect expense was incurred in purchasing 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.
- 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 (1 TAC Section 355.102(g)). Providers may incur these costs, but these costs cannot be considered part of HHSC's rate determination processes.

Amortization – The periodic reduction of an intangible asset's value over its useful life or the recovery of the intangible asset's cost over the useful life of the asset. Assets 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 land improvements. The amortization of goodwill is an unallowable cost. The amortization of a Medicaid contract's purchase price itself (as opposed to the physical facility's purchase price) is an unallowable cost. For additional information, see instructions for Step 8.e. and 1 TAC Section 355.103(b)(10).

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 paid by the individual in residential programs. 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. See 1 TAC Section 355.103(b)(20)(M) for more information.

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

Building/Facility/Building Equipment/Land/Leasehold Improvements. Building costs must exclude any goodwill (see definition for Goodwill).

Business Component – A separate business entity; a state contract, program, or grant; or an operation separate from the contracted provider's contract that makes up part of the total group of entities related by common ownership or control (i.e., one part of the entire related organization such as Medicare, CACFP, etc.). Each separate contract with the state of Texas is usually considered a separate business componentandentity. 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 multiple businesses. Central office costs are also known as allocated shared administrative costs. A separate corporation or partnership could provide the shared administrative functions or be a separate department or 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 adequately 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 1 TAC Section 355.103(b)(7) for more information.

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

Combined Entity – One or more commonly owned corporations or limited partnerships where identical persons control the general partner as the commonly owned corporation(s). It may involve an additional Controlling Entity, which owns all members of the combined entity.

Common Ownership – "Exists when an individual or individuals possess any ownership or equity in the contracted provider and the institution or organization serving the contracted provider." If a business entity provides goods or services to the provider and has common ownership with the provider, the business transactions between the two organizations are considered related-party transactions and must be adequately disclosed. Administrative costs shared between entities with common ownership must be adequately allocated and reported as central office costs (i.e., shared administrative costs). See the definition for Related-Party. See 1 TAC Section 355.102(i)(1) for more information.

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." See 1 TAC Section 355.103(b)(1) for more information.

Compensation of Owners and Related Parties – "Compensation includes both cash and non-cash forms of compensation subject to federal payroll tax regulations. Compensation includes withdrawals from an owner's capital account; wages and salaries (including bonuses); payroll taxes and insurance; and benefits. Payroll taxes and insurance include Federal Insurance Contributions Act (old age, survivors, and disability insurance (OASDI) and Medicare hospital insurance); Unemployment Compensation Insurance; and Workers' Compensation Insurance." Compensation must be made in regular periodic payments, subject to payroll or self-employment taxes, and verifiable by adequate documentation maintained by the contracted provider. See 1 TAC Section 355.103(b)(2) for more information.

Contract Labor – Labor provided by non-staff individuals. Non-staff refers to personnel who provide services to the contracted provider intermittently, whose remuneration (i.e., fee or compensation) is not subject to employer payroll tax contributions (e.g., FICA/Medicare, FUTA, or SUTA), and who perform tasks routinely performed by employees. Contract labor does not include consultants.

Contract Management – See definition for Management Services.

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

Contracted Provider – See definition for Provider.

Contracted Staff – See definition for Contract Labor.

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.

Contracting Entity – The business component Medicaid contracts with to provide the Medicaid services included in this cost report. See Instructions for Step 4.

Control – "Control exists if an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution." "...control includes any kind of control, whether or not it is legally enforceable and however it is exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise. Organizations, whether proprietary or nonprofit, are related through control to their directors in common." See 1 TAC Section 355.102(i)(1) and 1 TAC Section 355.102(i)(3) for more information.

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

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

Cost Report Group Code – The number used to identify an individual cost report. HHSC PFD will group one or more contracts for each legal entity into a cost report 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.** See 1 TAC Section 355.103(b)(10) for more information.

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 that can be specifically "charged" to a program should be charged to that program (i.e., direct costed or directly charged). Those general ledger entries shared by one or more programs should be adequately allocated between those programs that 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 and 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 the definition for Direct Costing.

Direct Costing – A method of assigning costs to specific 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 the 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 the definition of Building Costs.

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

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

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

Management Services – Services provided under contract between the contracted provider and a person or organization to provide for the operation of the contracted provider, including administration, staffing, maintenance, or delivery of resident/participant care services. Management services do not include contracts solely for maintenance, laundry, or food service. If the provider contracts with another entity for the management or operation of the program, the provider must report the specific direct services costs of that entity and not the amount for which the provider is contracting for the entity's services. "Expenses for management provided by the contracted provider's central office must be reported as central office costs on the cost report." See 1 TAC Section 355.103(b)(6) and 1 TAC Section 355.457(b)(2)(A) for more information.

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. See 1 TAC 355.102(f)(2) for more information.

Net Expenses – "Net expenses are gross expenses less any purchase discounts or returns and purchase allowances. Only net expenses should be reported on the cost report." See 1 TAC Section 355.102(k) and 1 TAC Section 355.103(b)(18)(D) for more information.

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 and participants include, but are not limited to, private pay, private insurance, Veterans Administration, 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. See 1 TAC Section 355.102(i)(2) and 1 TAC Section 355.103(b)(2)(A)(i) for more information.

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 contractually responsible for providing Medicaid services (i.e., the business component with which Medicaid contracts for providing the services to be reported in this cost report). Also known as a contracted provider. See the 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, 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 before being reported on the accountability report. See 1 TAC Section 355.102(k) for more information.

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 before being reported on the cost report. See 1 TAC Section 355.102(k) for more information.

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 at 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 services that are statewide and uniform by class of service and level of need.

Related – Related to a contracted provider means the contracted provider is associated or affiliated with, has control of, or is controlled by the organization furnishing services, equipment, facilities, leases, or supplies to a significant extent. See the definitions of Common Ownership, Control, and Related-Party at 1 TAC Section 355.102(i)(1) for more information.

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, 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. 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: (A) husband and wife; (B) natural parent, child, and sibling; (C) adopted child and adoptive parent; (D) stepparent, stepchild, stepsister, and stepbrother; (E) father-in-law, mother-in-law, brother-in-law, son-in-law, sister-in-law, and daughter-in-law; (F) grandparent and grandchild; (G) uncles and aunts by blood or marriage; (H) nephews and nieces by blood or marriage, and (9) first cousins." Disclosure of related-party information is required for all allowable costs reported by the contracted provider.

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. See 1 TAC Section 355.102(i) for more information.

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 and 1 TAC Section 355.103(b)(13)(B) for more information.

Startup Costs – "Are those reasonable and necessary preparation costs incurred by a provider in the period of developing the provider's ability to deliver services. Startup costs can be incurred prior to the beginning of a newly-formed business and/or prior to the beginning of a new contract or program for an existing business. Allowable startup costs include, but are not limited to, employee salaries, utilities, rent, insurance, employee training costs, and any other allowable costs incident to the startup period. Startup costs do not include capital purchases, which are purchased assets meeting the criteria for depreciation," as described in the Cost Determination Process rules. "Any costs that are properly identifiable as organization costs or construction costs must be appropriately classified as such and excluded from startup costs. Allowable startup costs should be amortized over a period of not less than 60 consecutive months. If the business component or corporation never commences actual operations, or if the new contract/program never delivers services, the startup costs are unallowable." See 1 TAC Section 355.103(b)(20)(D) for more information.

Vendor Hold – HHSC rules specify that Medicaid payments from HHSC may be withheld from contracted providers in 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

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; instead, these costs should be reported as Administration Costs. See the definition of Safety Program for more information.