2024 Accountability Report Instructions for Residential Care (RC)

Provider Finance Department, Long-Term Services and Supports

Texas Health and Human Services Commission (HHSC)

TEXAS
Health and Human Services

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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 Attendant Compensation 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.

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 Accountability 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.
- Step 6.c. Attendants
  - Providers have been reporting Regular, Overtime and Bonuses and Incentives, in one entry. The provider is now required to split these fields into Regularegisteredr Hours, Overtime Hours, and Other Compensation.

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 and 355.112;
- RC program-specific rules at 1 TAC Section 355.509;
- 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; and
- 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 ue 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 unbankruptcy 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).
- Attendant care staff salaries and wages and attendant contract labor compensation (see Appendix H. Definitions, Attendant Care for Community, for detailed instructions on reporting attendant care staff time, salaries, and wages).
- 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; and
- 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, and
- 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.

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.
- 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	
PHC	
RC *	Yes

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 Attendant Compensation 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 and 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	100004001	ZZZ RAD RC	RC	RC AL STAR+PLUS	n/a n/a n/a	123456901 123456902 123456904	ZZZ RAD RC ZZZ RAD RC ZZZ RAD RC	RC RC	
Yes No	100004002	ZZZ RAD RC	RC	AL	n/a	123456903	ZZZ RAD RC	RC	
Yes No	100004003	ZZZ RAD RC	RC	STAR+PLUS	n/a	123456909	ZZZ RAD RC		

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 leftmost 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		Other - provide explanation:Pizza Restaurant		123456789	HHSC RAD	
	Yes		Child and Adult Care Food Program (CACFP)		123456	HHSC RAD	

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	100004001	ZZZ RAD RC	RC	
Requested	100004002	ZZZ RAD RC	RC	
Requested	100004003	ZZZ RAD RC	RC	

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 7:27 AM

Save | Save and Return | Cancel

National Provider Identifier (NPI) #: Please contact HHSC at costinformationpfd@hhs.texas.gov if the provider believes this is not their current NPI number.	136, 137
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)**: Sole Proprietor (selected); 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 Rate Enhancement for the entire reporting period for this accountability report group for RC 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 100015-2024-test.txt Select file or upload new file
Upload an organizational chart. The organizational chart must include the employee name, position, and any related party information.	100015-2024-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

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 Attendant Compensation 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 AdjustmentsWhen 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 You Provide Units of Service During this Cost Reporting Period?

Click either “Yes” or “No.” If “No,” you may be eligible for a cost report excusal. If you have provided any services during the reporting period, click “Yes.” If not, please contact HHSC PFD at CostInformationPFD@hhs.texas.gov. Please refer to the “Who Must Complete this Report” section of these instructions.

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

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 followup 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

Total number of Licensed Beds at the End of the Reporting Period: *	
Total number of Contracted Beds at the End of the Reporting Period: *	

Save | Save and Return | Cancel

Report the total number of licensed and contracted beds at the end of the reporting period.

Step 5.b. Residential Care (RC) Resident Days

Resident Days				
Service	Rate Period 2 01/01/2022 - 08/31/2022	Rate Period 3 09/01/2022 - 12/31/2022	Total Resident Days	Private and Other Revenue
RC Apartment				
RC Non-Apartment				
Private Pay				
Non-Reimbursed Service				
TOTAL	0	0	0	$0

Important Note: There is no location for entering Medicaid revenues for RC services. Those revenues are not to be entered in the cost report.

Report the total number of resident days during the reporting period for HHSC RC clients. These are the clients you are responsible for providing residential care services for under the HHSC contract(s) listed in **Step 3.a.** The preparer 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 in **Step 5.b.** based on the provider's reporting period in **Step 4.**

Private Pay

Record any units of service and revenue for services that were paid by another payer source as private pay. This category can include both private pay and private insurance. Do **NOT** report the following in this category:

- Veterans Administration and Qualified Medicare Beneficiary (QMB),
- STAR Kids, Medically Dependent Children's Program (MDCP),
- Personal Care Services (PCS), or
- Other forms of Medicaid services.

Do not include Medicare or federal government services or other business components not listed.

Non-Reimbursed Services

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

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 a private payer source but are associated with costs incurred during the cost reporting period and reported in **Step 6** or **Step 8** on the cost report, these units should be reported under non-reimbursed.

Step 5.c. Assisted Living (AL) Resident Days

Assisted Living (AL) clients are those individuals who are eligible and enrolled in the STAR+PLUS Waiver Program and receive assisted living services in your facility. Report the number of resident days associated with these clients.

Resident Days				
AL Single Occupancy Apartment	Rate Period 2 01/01/2022 - 08/31/2022	Rate Period 3 09/01/2022 - 12/31/2022	Total Resident Days	Private and Other Revenue
AL 1			0	
AL 2			0	
AL 3			0	
AL 4			0	
AL 5			0	
AL 6			0	
Private Pay			0	
Non-Reimbursed Service			0	
TOTAL	0	0	0	$0

Resident Days				
RC Double Occupancy Apartment	Rate Period 2 01/01/2022 - 08/31/2022	Rate Period 3 09/01/2022 - 12/31/2022	Total Resident Days	Private and Other Revenue
AL 1			0	
AL 2			0	
AL 3			0	
AL 4			0	
AL 5			0	
AL 6			0	
Private Pay			0	
Non-Reimbursed Service			0	
TOTAL	0	0	0	$0

Resident Days				
RC Non-Apartment	Rate Period 2 01/01/2022 - 08/31/2022	Rate Period 3 09/01/2022 - 12/31/2022	Total Resident Days	Private and Other Revenue
AL 1			0	

Step 5.d. Other Revenues

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

In this section, the preparer will report other revenues to support services not reported in **Step 5.c.**

5.e. Other Revenue

Last Verified by Rate Analysis Test on 12/20/2021 1:49 PM

Save | Save and Return | Cancel

Do you have any other revenue not reported in the various Step 5 sub steps? Yes

Type	Revenue
Unrestricted Gifts, Grants, and Income from Endowments from Private Sources	100.00
Grants and Contracts from Federal, State, and Local Government Sources	0.00
TOTAL	100.00

Does any of your Federal, State, and Local Government revenue offset costs reported elsewhere in this report? --

Does the Provider have any other Types of Revenue not Reported in Steps 5.a. – 5.c.?

If "Yes," a table will open to report any additional revenues used to pay for expenses for services reported on the cost report.

Unrestricted Gifts, Grants, and Income from Endowments from Private Sources

Revenue not offset. Report revenues from other payment sources not listed in **Steps 5.a.** to **5.c**. Revenues reported under "Unrestricted Gifts, Grants, and Income from Endowments from Private Sources" should include any revenue used to pay for expenses reported on the cost report from private sources not previously listed in **Steps 5a** to **5c**.

Unrestricted or restricted grants, gifts, and income from privately-sourced endowments used to purchase allowable program items should not be offset before reporting on the cost report. All unrestricted funds that are properly allocable to the cost report should be reported on the cost report, as well as any allowable costs to which the unrestricted funds were applied.

Grants and Contracts from Federal, State, and Local Government Sources

Offset grants and contracts from federal, state, or local government, such as transportation grants, United States Department of Agriculture grants, education grants, Housing and Urban Development grants, and Community Service Block Grants, before reporting on the cost report. They should be offset against the particular cost or group of costs for which the grant was intended.

Report revenues acquired through grants and contracts from federal, state, and local government sources not previously listed in **Steps 5.a.** to **5.c.** Revenues reported under Federal, State, and Local Government Sources should include any revenue used to pay for expenses from public or government sources not previously listed in **Steps 5.a.** to **5.c**.

Does any of the Provider’s Federal, State, and Local Government Revenue Offset Costs Reported Elsewhere in this Report?

Select “Yes” to confirm that any federal, state, and local government revenue was offset against the cost or group of costs the grant was intended for before reporting the expenses on the cost report, as per 1 TAC Section 355.103(b)(18).

> **Note**: Provider Relief Funds (PRF) revenue recognized during the provider’s reporting period because of lost revenue should not reduce any expenses included on the unadjusted trial balance before reporting those expenses on the cost report. These lost revenue dollars are not associated with any specific expense. This PRF revenue recognized as a result of lost revenue should instead be reported as “Unrestricted Gifts, Grants, and Income from Endowments and Private Sources” on **Step 5.d.** of the cost report, as applicable. It will have no impact on the allowable expenses reported.

Step 6. Wages and Compensation

Purpose

The purpose of **Step 6** is to collect wages, compensation, and benefits information for the contracted provider’s attendant, non-attendant, 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 spending compliance in the 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 proceed with the rest of the questions.

Please Select "Yes" or "No" for the Following Self-Insurance Expenses 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 each employee 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 H. 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 verify at this time they are completely sure there are no related party wages or compensation in this 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. Include Owner-Employee information 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. 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 so as 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 Benefit

Note: This section is not applicable to the Accountability Report.

The information entered in the following **Step 6.a.** tables will allow HHSC PFD to evaluate the difficulties providers face with staff recruitment and retention, especially for attendant staff, and will help HHSC assess how to help providers alleviate these issues going forward. Please note that the information in the following **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 more or less 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, or
- N/A (no staff of this type).

Staff Retention Information

Staff Retention Information

		Number of staff who left:			
Position Type	**Number of staff (Full-time, Part-time, Temp, Medicaid, Non-Medicaid & Private Pay combined) on 12/31/2018**	**1/1/2018 - 6/30/2018**	**7/1/2018 - 12/31/2018**	**Number of vacancies on 12/31/2018**	**Pe no**
Attendants					
Employment Services (SE, EA)					
Nurses (RNs, LVNs)					
Specialists (PT, OT, Dietary, etc.)					
Central Office Staff					
Administrative and Operations Staff					
TOTAL	0	0	0	0	

Length of Time with your Agency	**Using the total number of staff from above, what is the length of time they have been with your agency?**
LESS than 6 months	
BETWEEN 6 and 12 months	
OVER 12 months	
Total Staff by Length of Time	0

These values must match

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

Enter the number of attendants 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.

Attendant Benefits Information

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.

Table 1. Attendant Benefits Information

In addition to wages, does your agency offer benefits to attendants?If Yes, check all that apply	Full-time Attendants	Part-time Attendants
Medical Insurance (paid in whole or in part by agency)		
Dental Insurance (paid in whole or in part by agency)		

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

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

For Each Owner-Employee, Related-Party Employee, and Related-Party Contract Staff, click "Add record" and 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. Enter the business component by following the instructions below:

- **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.

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
									$0

Business Component & Line Item Allocation

100001002 - CPC Add Record

	Hours	Compensation
100001001 - CPC		$0

Line Item	Site Type	Job Title	Position Type	Description Of Duties	Employed/Contracted	Total Hours Worked	Compensation
--	n/a						$0
Add Line Item							
TOTAL						0	$0

Attach Organization Chart 1 — Select file or upload new file
Attach Organization Chart 2 (Optional) — Select file or upload new file
Attach Organization Chart 3 (Optional) — Select file or upload new file
Select Line Item Allocation Methodology
Attach Methodology — Select file or upload new file

TOTAL .00 $0

Select Business Component Allocation Methodology
Attach Methodology — Select file or upload new file

Save Cancel

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

Enter Line-Item Allocation(s):

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
									$0

Business Component & Line Item Allocation

100001002 - CPC Add Record

	Hours	Compensation
100001001 - CPC		$0

Line Item	Site Type	Job Title	Position Type	Description Of Duties	Employed/Contracted	Total Hours Worked	Compensation
--	n/a						$0
Add Line Item							
TOTAL						0	$0

Attach Organization Chart 1 — Select file or upload new file
Attach Organization Chart 2 (Optional) — Select file or upload new file
Attach Organization Chart 3 (Optional) — Select file or upload new file
Select Line Item Allocation Methodology
Attach Methodology — Select file or upload new file

TOTAL .00 $0

Select Business Component Allocation Methodology
Attach Methodology — Select file or upload new file

Save Cancel

- **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. Attendant staff types may only be used for staff who meet the attendant definition. See Appendix H. Definitions, *Attendant Care for Community*. Note which staff can be classified as an attendant and which cannot.
- **Job Title** – Related-party's title within the specific business component.

- **Position Type** – Identify the type of position (e.g., central office, management, administrative, direct care, nurse, or direct care supervisory) filled by the related individual.
- **Description of Duties** – 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. Include Owner-Employee information 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. 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. Attendant

Non-Related Party								
Total Staff Hours	Staff Regular Hours	Staff Overtime Hours	Total Contracted Hours	Total Contracted Payments	Total Staff Wages	Staff Regular Wages	Staff Overtime Wages	Total Contracted Wages
B	C	D	E	F	G	H	I	J

Related Party								
Total Staff Hours	Staff Regular Hours	Staff Overtime Hours	Total Contracted Hours	Total Contracted Payments	Total Staff Wages	Regular Wages	Overtime Wages	Total Contracted Wages
K	L	M	N	O	P	Q	R	S

Related Party and Non-Related Party						
Employee Benefits/Insurance	Miles Traveled	Mileage Reimbursement	Total Compensation	Average Staff Rate	Average Contracted Rate	Average Mileage Reimbursement per mile
T	U	V	W	X	Y	Z

Staff Regular Hours, Staff Overtime Hours, Total Staff Hours, Staff Regular Wages, Staff Overtime Wages, Non-Hourly Compensation, Total Staff Compensation, Total Contract Hours, and Total Contract Payment

- **Columns B-J** are for Non-Related Party attendants.
- **Columns K-S** are for Related Party attendants.

All related-party attendants must be entered through **Step 6.b.** above. For each attendant staff service type, enter the regular and overtime hours, wages, and contract compensation for non-related-party employees and contract staff who meet the attendant definition. See Appendix H. Definitions, *Attendant Care for Community*. Only employees and contracted staff who meet the attendant definition may be reported in these cost items.

- **Staff Regular Hours** are individual employee hours 40 hours per week or less. See 1 TAC Section 355.103(b)(2)(A)(iii) for more information.
- **Staff Overtime Hours** are hours over the 40-hour week for full-time employees. These employees are to be reimbursed at 1.5 times their pay rate. For more information, refer to the Texas Comptroller of Public Accounts website under Texas Payroll/Personnel Resource.

- **Total Staff and Total Contract Hours** should include the total hours for which employees and contract labor attendants were compensated during the reporting period. Total Staff Hours would include hours for both time worked and paid time off (regular hours, overtime hours, sick leave, vacation, etc.)
- **Non-Hourly Compensation** usually consists of bonuses or incentives, including discretionary or non-discretionary payment or "compensation" to an employee outside of their regular hourly pay rate, subject to taxes, but not an hourly wage rate or overtime rate.

If there are related-party employee and contract attendant staff reported in **Step 6.b.** above, these columns are automatically populated after all non-related-party costs in Columns B-J have been entered.

> **Note:** While the offset of some of the PRF and Payroll Protection Plan (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 PRF or PPP dollars were used to pay for the salary, 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.

Employee Benefits/Insurance – Column T

This column is for related and non-related-party employee attendant staff. Include the following benefits in this column for all attendants by service type. Except for paid claims where the employer is self-insured, these benefits must be direct costed, not allocated.

- Accrued Vacation and Sick Leave*
- Employer-Paid Health, Medical, and Dental Premiums
- Employer-Paid Disability Insurance Premiums
- Employer-Paid Life Insurance Premiums
- Employer-Paid Contributions to acceptable retirement funds or 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 also reported, either the same or another year, as salaries and wages. 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), are not to be reported as benefits. Examples include the contracted provider's unrecovered cost of uniforms, staff personal vehicle mileage reimbursement, job-related training reimbursements, and job certification renewal fees. These costs should instead 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.

Miles Traveled and Mileage Reimbursement –Columns U & V

These columns are for related and non-related-party employee attendant staff. Include the personal vehicle miles traveled and the mileage reimbursement paid for allowable travel and transportation in the staff person’s personal vehicle for all attendants by service type. Allowable travel and transportation include mileage and reimbursements of attendant staff who transport individuals to and from DAHS program services and activities in their personal vehicle unless payroll taxes are withheld on the reimbursements. In that case, reimbursement should be included as salaries and wages of the appropriate staff. Allowable travel and transportation also include mileage and reimbursements of attendant staff for traveling 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

Total Compensation – Column W

This column is the sum of Columns H, Q, S, T, and V and represents the Total Attendant Compensation for that service type.

Average Staff Rate – Column X

This column is the result of Columns E, F, N, and O divided by Columns D + M and represents the average staff contract rate of all staff, both related and non-related parties.

Average Contract Rate – Column Y

This column is the result of Columns J + S divided by Columns I +R and represents the average hourly contract rate of all contract staff for both related and non-related parties.

Average Mileage Reimbursement per Mile – Column Z

This column is the result of Column V divided by Column U. This amount should never exceed the highest allowable mileage rate for the provider's fiscal year.

Step 6.d. Non-Attendant

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

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 attendant, non-attendant, 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 attendant staff, non-attendant/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 percentage of salaries is not the salaries allocation method since the salaries allocation method includes both salaries and contract labor.

7. Payroll Taxes and Workers' Compensation

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

Attach supporting Documentation (e.g., TWC Form C-66R (0891) 'Notice of Maximum Potential Charge - Reimbursing Employer' or a copy of a quarterly TWC report or notification letter from TWC) Select file or upload new file

Taxes and Workers' Compensation	Attendant	Non-Attendant and Program Admin	Central Office	Total
FICA and Medicare Payroll Taxes				0
State and Federal Unemployment Taxes				0
Workers' Compensation Premiums				0
Workers' Compensation Paid Claims				0

Save | Save and Return | Cancel

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

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

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

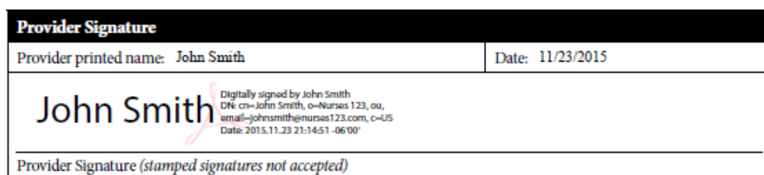
Save | Save and Return | Cancel

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:

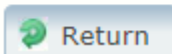
- printed on the contracted provider's letterhead;
- signed by an individual legally responsible for the conduct of the contracted provider, such as the sole proprietor, a partner, a corporate officer, an association officer, a governmental official, or a limited liability company member; and
- scanned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

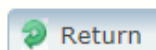
Texas Health and Human Services Commission
Rate Analysis Department, MC H-400
P.O. Box 149030
Austin, TX 78714-9030

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 salaries allocation method:

- Salaries/wages
- Contracted labor (excluding consultants)

In the cost component above, the term "salaries" does not include the following costs associated with the salaries 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 Unemploy-ment	$ 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

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%)
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
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
Telecomm unications	$ 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 – Malpract-ice	$ 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

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%)
Miscellan-eous	$ 601.47	$ 254.74				$ 346.73	$ 143.82	$ 106.52	$ 96.39
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

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%)
Employee Benefits/ Insurance	$ 4,847.25		$ 1,254.01	$ 889.47	$ 1,358.41	$ 1,345.36	$ 307.68	$ 680.62	$ 357.06
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
Telecomm unications	$ 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 – Malpract-ice	$ 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
Miscellan-eous	$ 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/Medi care	$ 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)

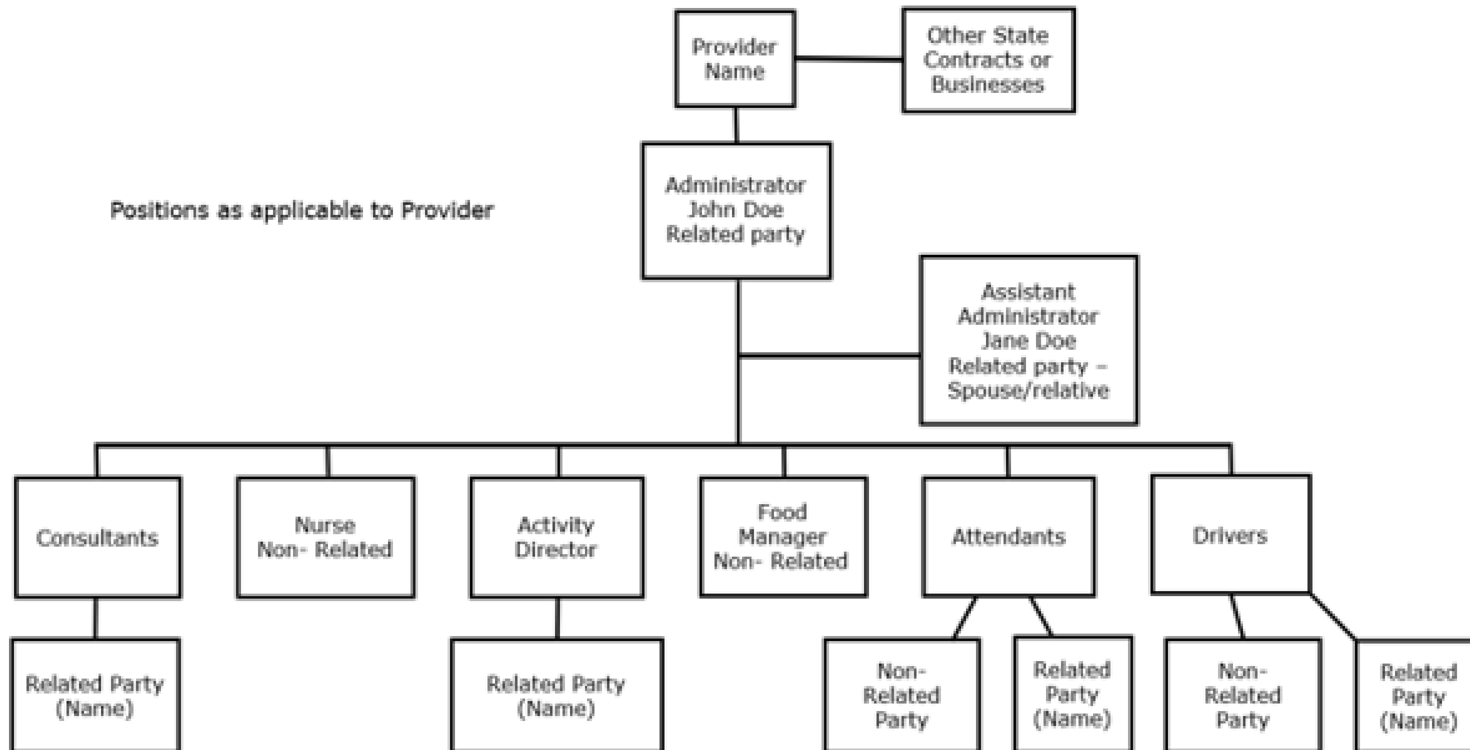
As of (enter begin and end dates)

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 – Administrative	$ 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 Unemployment	$ 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. Organizational Flowchart Example



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):

Table 2. Minimum Depreciation Schedule.

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 3. 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 Instructions."

Appendix G. 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 H. 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).

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.

Attendant Care for Community – "An attendant is the unlicensed caregiver providing direct assistance to individuals with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)" (1 TAC Section 355.112(b)). "Attendants do not include the director, administrator, assistant director, assistant administrator, clerical and secretarial staff, professional staff, other administrative staff, licensed staff, attendant supervisors… or maintenance…staff" (1 TAC Section 355.112(b)(2)). See the TAC reference for additional details and exceptions.

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.

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

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

Contract Management – See definition for Management Services.

Contracted Provider – See definition for Provider.

Contracted Staff – See definition for Contract Labor.

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

Direct Cost – An allowable expense incurred by the provider specifically designed to provide services for this program. If a general ledger account contains costs (including expenses paid with federal funds) attributable to more than one program, the individual entries to that general ledger account 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.

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.

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-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-Reimbursed Service – Report any units where an individual received services, but any payer source did not reimburse the unit. This can include individuals served who lost Medicaid eligibility and were not reimbursed; thus, there is no associated revenue at the time.

Owner – "An individual (or individuals) or organization that possesses ownership or equity in the contracted provider organization or the supplying organization..." "A person who is a sole proprietor, partner, or corporate stockholder-employee owning any of the outstanding stock of the contracted provider is considered an owner," regardless of the percentage of ownership. See 1 TAC Section 355.102(i)(2) and 1 TAC Section 355.103(b)(2)(A)(i) for more information.

Private Pay – Report any units of service and revenue for services paid by another payer source. This can include private pay and private insurance. Do not report: Veterans Administration and QMB, STAR Kids, MDCP, PCS, or other Medicaid services. Do not include Medicare or federal government services or other business components not listed.

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.

Step 6 and **Step 8** of STAIRS both have sub-steps designed for reporting compensation of related parties (both wage and contract compensation) and

related-party transactions, including the purchase/lease of equipment, facilities, or supplies, and the purchase of services, including related-party loans (i.e., lending services). See also the definitions of Common Ownership, Control, Related, and Related-Party Transactions. See also the Cost Report Training materials. See 1 TAC Section 355.102(i) for more information.

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.

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.