TEXAS REGISTER

# IN THIS ISSUE

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## Part I - Volume 20, Number 57

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**Texas Register**

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## How to Use the Texas Register

**Information Available**: The 11 sections of the *Texas Register* represent various facets of state government. Documents contained within them include:

**Governor** - Appointments, executive orders, and proclamations.

**Attorney General** - summaries of requests for opinions, opinions, and open records decisions

**Secretary of State** - opinions based on the election laws.

**Texas Ethics Commission** - summaries of requests for opinions and opinions.

**Emergency Rules**- sections adopted by state agencies on an emergency basis.

**Proposed Rules** - sections proposed for adoption.

**Withdrawn Rules** - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date.

**Adopted Rules** - sections adopted following a 30-day public comment period.

**Tables and Graphics** - graphic material from the proposed, emergency and adopted sections

**Open Meetings** - notices of open meetings

**In Addition** - miscellaneous information required to be published by statute or provided as a public service.

Specific explanation on the contents of each section can be found on the beginning page of the section. The division also publishes cumulative quarterly and annual indexes to aid in researching material published.

**How to Cite**: Material published in the *Texas Register* is referenced by citing the volume in which the document appears, the words "TexReg" and the beginning page number on which that document was published. For example, a document published on page 2402 of Volume 20 (1995) is cited as follows: 20 TexReg 2402.

In order that readers may cite material more easily, page numbers are now written as citations Example: on page 2 in the lower-left hand corner of the page, would be written "20 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 20 TexReg 3."

**How to Research**: The public is invited to research rules and information of interest between 8 a.m. and 5 p.m. weekdays at the *Texas Register* office, Room 245, James Earl Rudder Building, 1019 Brazos, Austin. Material can be found using *Texas Register* indexes, the *Texas Administrative Code*, section numbers, or TRD number.

## Texas Administrative Code

The *Texas Administrative Code* (*TAC*) is the official compilation of all final state agency rules published in the *Texas Register*. Following its effective date, a rule is entered into the *Texas Administrative Code*. Emergency rules, which may be adopted by an agency on an interim basis, are not codified within the *TAC*. West Publishing Company, the official publisher of the *TAC*, publishes on an annual basis.

The *TAC* volumes are arranged into Titles (using Arabic numerals) and Parts (using Roman numerals). The Titles are broad subject categories into which the agencies are grouped as a matter of convenience. Each Part represents an individual state agency. The *Official TAC* also is available on WESTLAW, West's computerized legal research service, in the TX-ADC database.

To purchase printed volumes of the *TAC* or to inquire about WESTLAW access to the *TAC* call West: **1-800-328-9352.**

The Titles of the *TAC*, and their respective Title numbers are:

1. Administration
4. Agriculture
7. Banking and Securities
10. Community Development
13. Cultural Resources
16. Economic Regulation
19. Education
22. Examining Boards
25. Health Services
28. Insurance
30. Environmental Quality
31. Natural Resources and Conservation
34. Public Finance
37. Public Safety and Corrections
40. Social Services and Assistance
43. Transportation

**How to Cite**: Under the *TAC* scheme, each section is designated by a *TAC* number. For example in the citation 1 TAC §27.15:

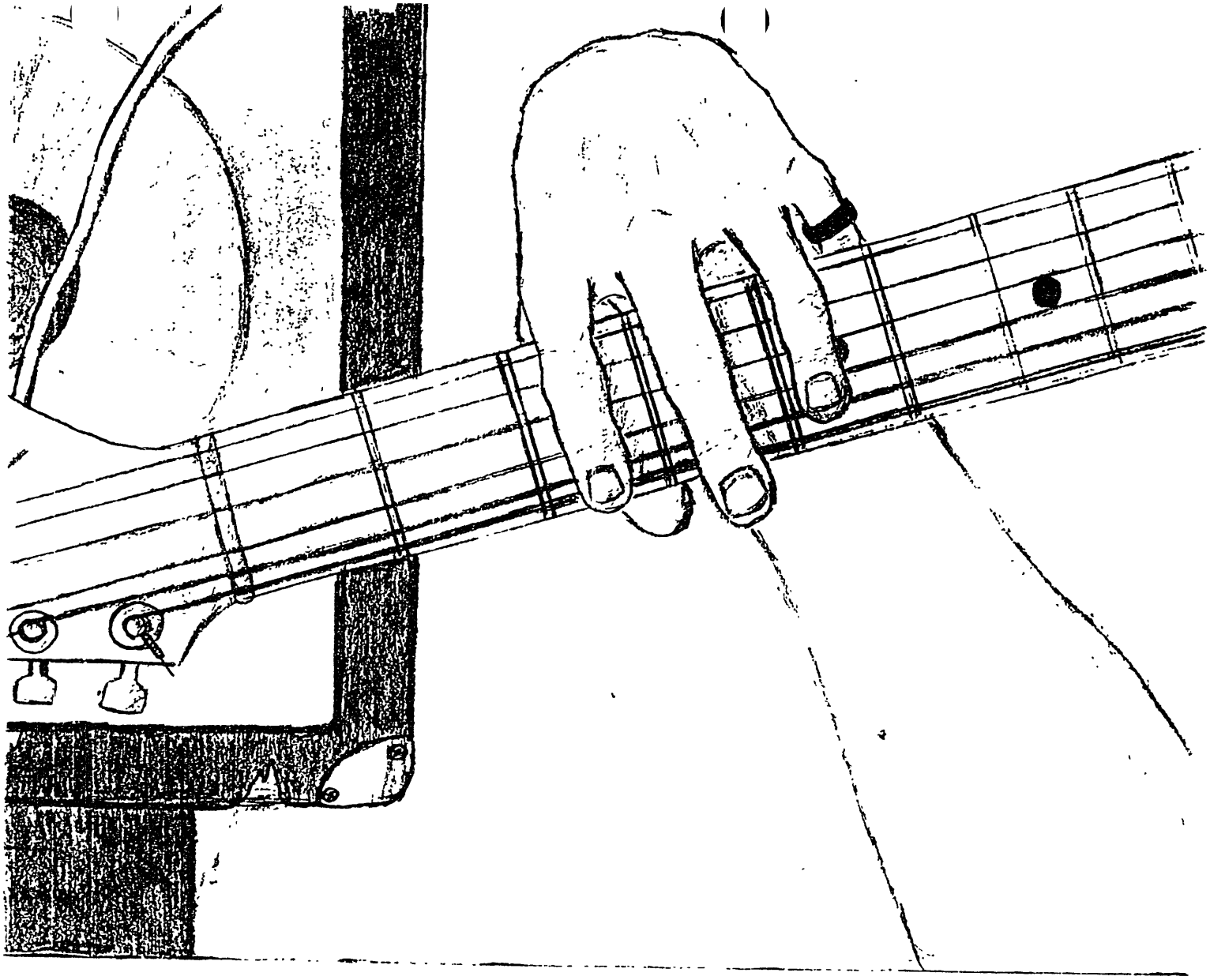
1 indicates the title under which the agency appears in the *Texas Administrative Code*; *TAC* stands for the *Texas Administrative Code*; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

**How to update**: To find out if a rule has changed since the publication of the current supplement to the *Texas Administrative Code*, please look at the *Table of TAC Titles Affected*. The table is published cumulatively in the blue-cover quarterly indexes to the *Texas Register* (January 21, April 15, July 12, and October 11, 1994). In its second issue each month the *Texas Register* contains a cumulative *Table of TAC Titles Affected* for the preceding month. If a rule has changed during the time period covered by the table, the rule's *TAC* number will be printed with one or more *Texas Register* page numbers, as shown in the following example.

TITLE 40. SOCIAL SERVICES AND ASSISTANCE
*Part I. Texas Department of Human Services*
40 TAC §3.704.....950, 1820

The *Table of TAC Titles Affected* is cumulative for each volume of the *Texas Register* (calendar year).

**Update by FAX**: An up-to-date *Table of TAC Titles Affected* is available by FAX upon request. Please specify the state agency and the TAC number(s) you wish to update. This service is free to *Texas Register* subscribers. Please have your subscription number ready when you make your request. For non-subscribers there will be a fee of $2.00 per page (VISA, MasterCard). (512) 463-5561.



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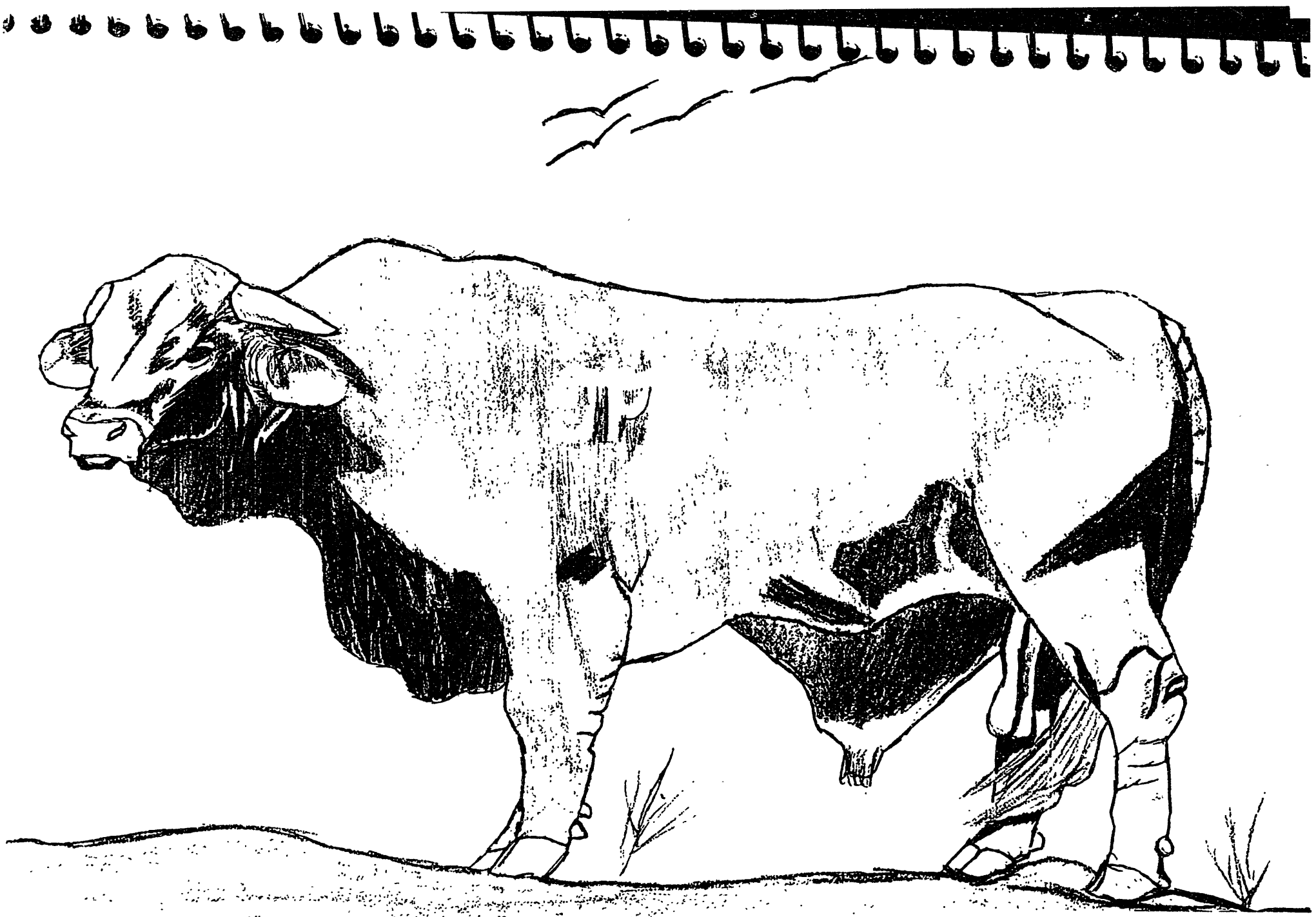

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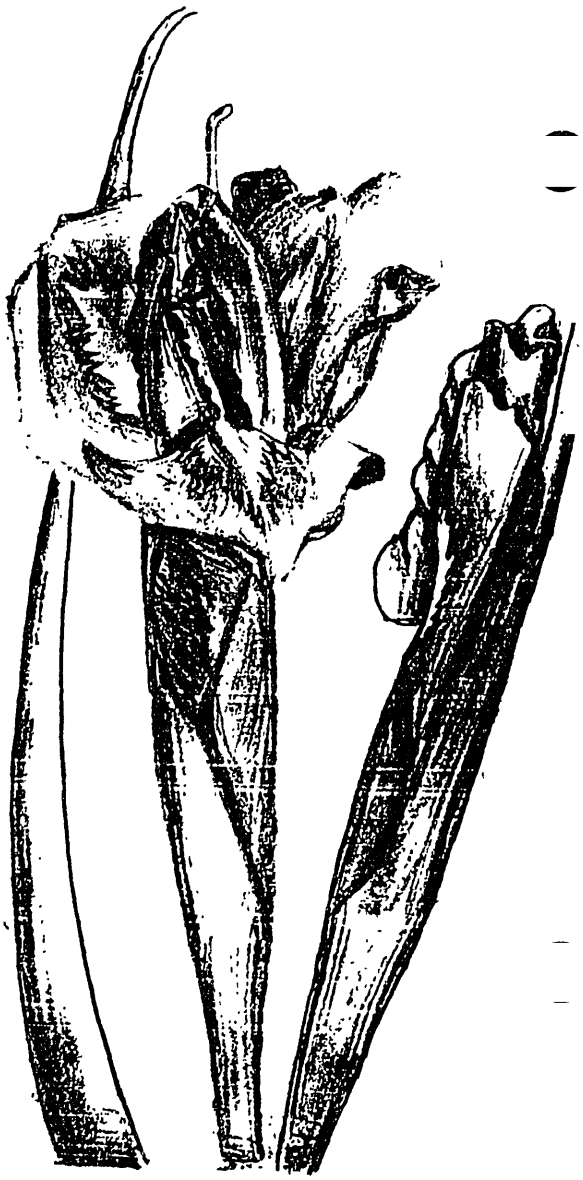

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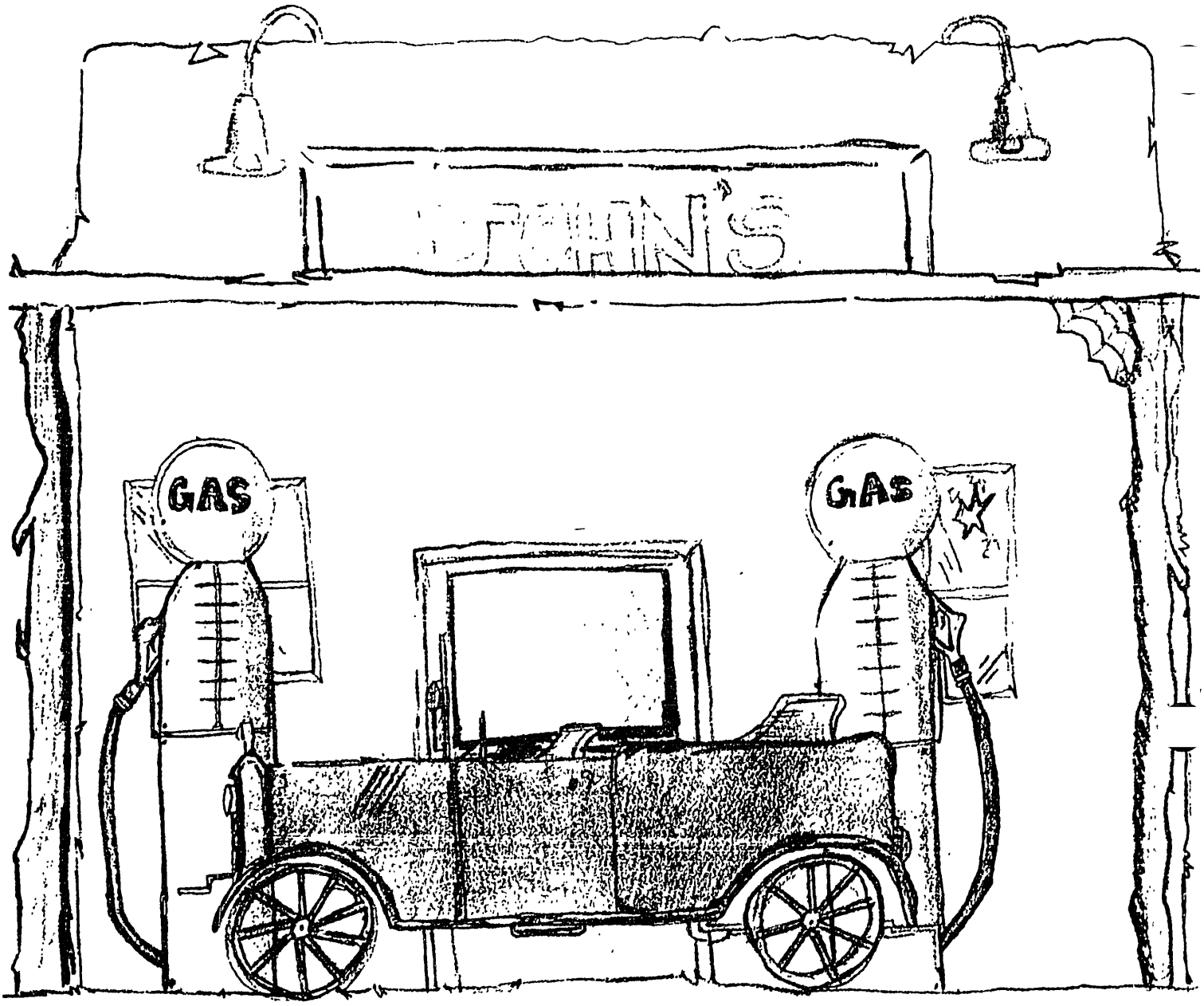


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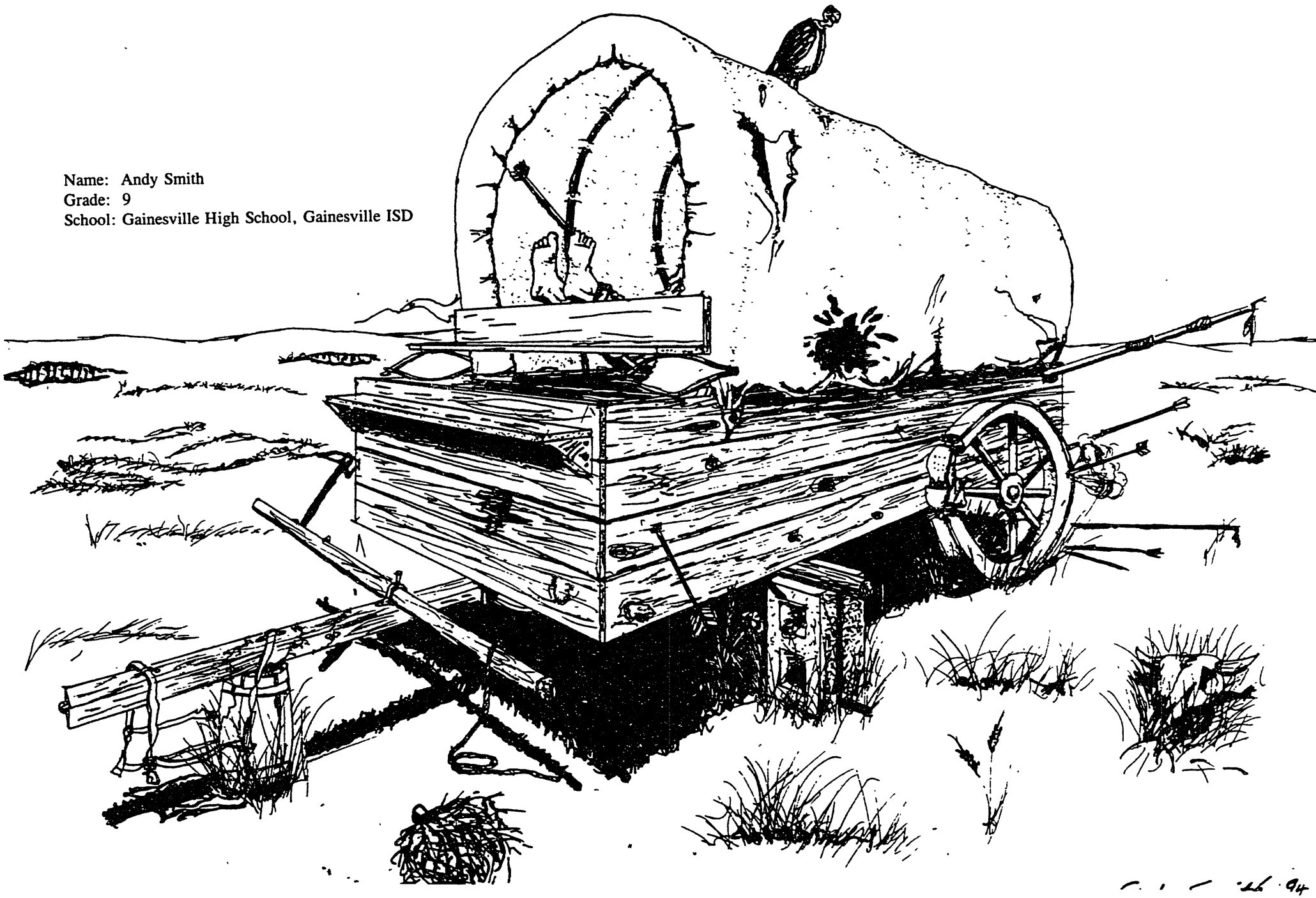

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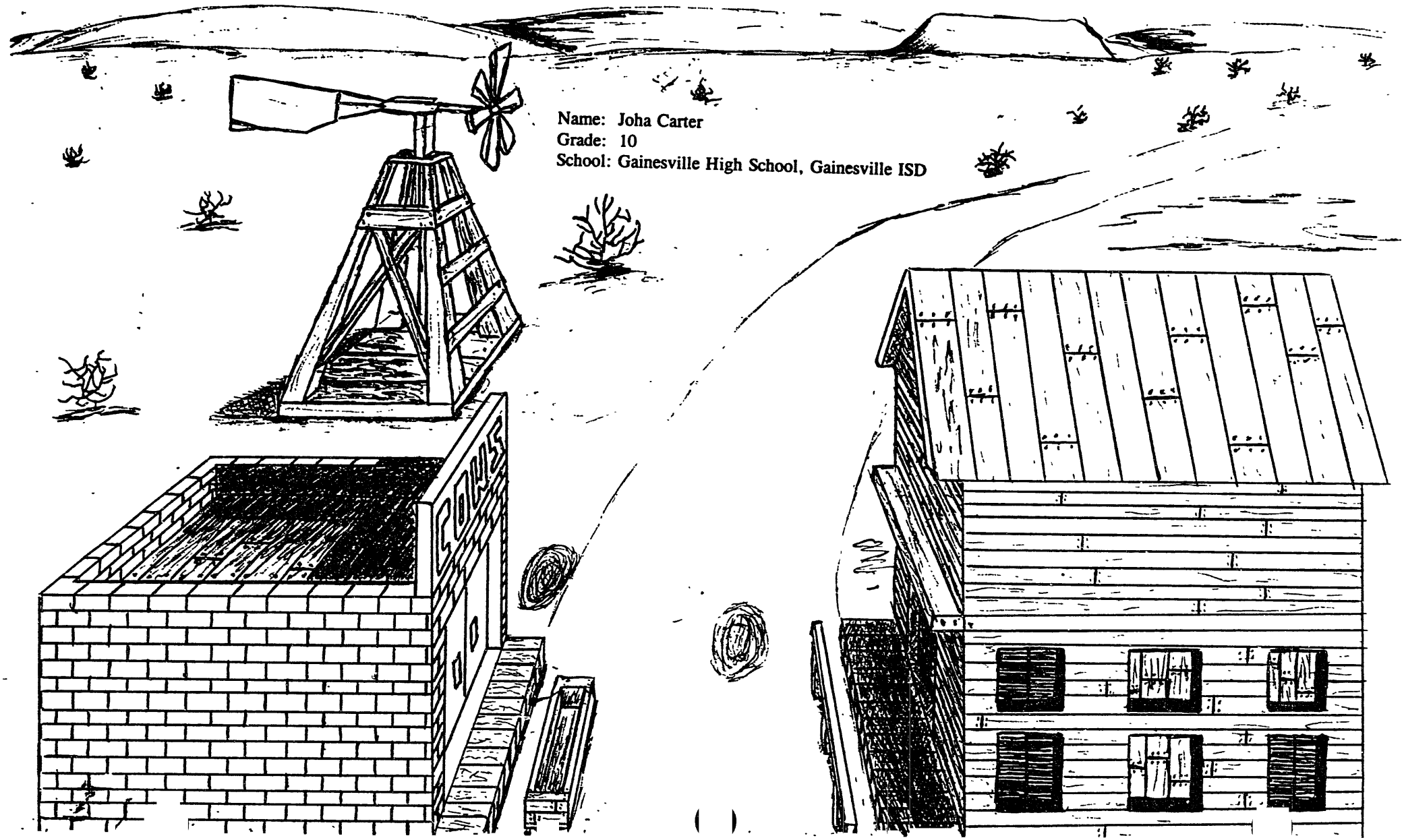


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# TEXAS ETHICS COMMISSION

The Texas Ethics Commission is authorized by Government Code, §571.091, to issue advisory opinions in regard to the following statutes: the Government Code, Chapter 302; the Government Code, Chapter 305; the Government Code, Chapter 572; the Election Code, Title 15; the Penal Code, Chapter 36; and the Penal Code, Chapter 39.

Requests for copies of the full text of opinions or questions on particular submissions should be addressed to the Office of the Texas Ethics Commission, P.O. Box 12070, Austin, Texas 78711-2070, (512) 463-5800.

## Texas Ethics Commission

### Ethics Advisory Opinions

**EAO-270 (AOR 276).** Whether contributions to a fund to be used for the purpose of financing a private lawsuit seeking to overturn federal control over Texas prisons are subject to title 15 of the Election Code.

**Summary of Opinion.** A group that accepts contributions and makes expenditures to assist members of the legislature acting in their capacity as legislators in filing a lawsuit is a political committee for purposes of title 15 of the Election Code.

**EAO-271 (AOR-301).** Whether a specific-purpose political committee formed to support a candidate must report the use of the candidate's personal equipment as a political contribution to the committee.

**Summary of Opinion.** A specific-purpose political committee supporting a candidate has an identity separate from the candidate. If the candidate makes a transfer to the committee, the committee must report a contribution from the candidate.

**EAO-272 (AOR-304).** Whether a county political party may use corporate contributions to pay for brochures and voter registration drives.

**Summary of Opinion.** A county executive committee of a political party may not use corporate contributions to pay the costs associated with the printing and distribution of brochures soliciting donations to and membership in the party or the costs associated with voter registration drives.

Issued in Austin, Texas, on July 19, 1995

TRD-9509061 Sarah Woelk
Director, Advisory Opinions
Texas Ethics Commission

Filed: July 19, 1995

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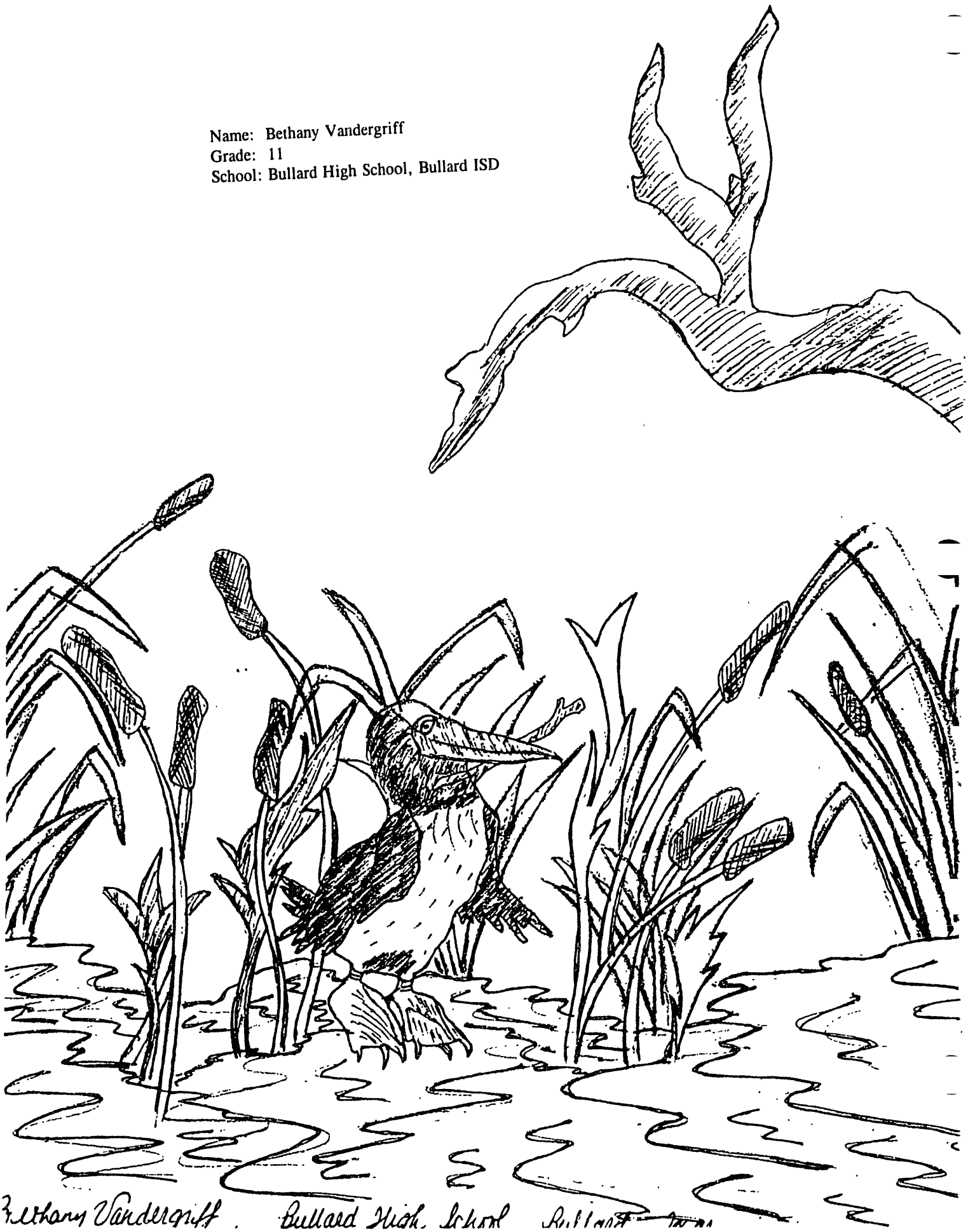

# PROPOSED RULES

Before an agency may permanently adopt a new or amended section or repeal an existing section, a proposal detailing the action must be published in the ***Texas Register*** at least 30 days before action is taken. The 30-day time period gives interested persons an opportunity to review and make oral or written comments on the section. Also, in the case of substantive action, a public hearing must be granted if requested by at least 25 persons, a governmental subdivision or agency, or an association having at least 25 members.

**Symbology in proposed amendments.** New language added to an existing section is indicated by the use of **bold text.** [Brackets] indicate deletion of existing material within a section.

## TITLE 7. BANKING AND SECURITIES

## Part II. Banking Department of Texas

### Chapter 25. Prepaid Funeral Contracts

### Subchapter B. Regulation of Licenses

• 7 TAC §25.25

The Banking Department of Texas (the Department) proposes new 7 TAC §25.25 concerning the conversion of prepaid funeral contracts from trust funded benefits to insurance funded benefits, as provided for under Texas Civil Statutes, Article 548b (the Act), §1A.

The conversion of prepaid funeral contracts to insurance funded benefits from trust funded benefits is permissible under the Act, §1A, if the insurance funded arrangement will safeguard the rights and interests of the individual prepaid funeral contract purchasers to substantially the same degree as or greater degree than the trust funded arrangement. In the past, the Department has reviewed insurance conversion applications and based its determination on the quality and extent of benefits under the insurance policy, as well as the status and condition of the applicant funeral home and the insurer, as a way of determining whether the proposed insurance funded arrangement would safeguard the rights and interests of the individual prepaid funeral contract purchasers to the same degree as or a greater degree than provided under the existing trust funded arrangement, see Texas Attorney General's Opinion Number MW-336 (1981) While relatively few insurance companies have been involved in these conversions in the past, interest in insurance conversions has grown among insurers in Texas.

The Department proposes new §25.25 in order to more clearly outline the basic requirements for an application for conversion under the Act, §1A. As proposed, §25.25 would also set forth the standards for approval of the conversion application and the required documentation that must accompany an application for conversion, as well as information relevant to requesting a hearing on an application prior to final denial by the Department

Brian R. Herrick, Assistant General Counsel, Texas Department of Banking, has determined that for the first five-year period the section is in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the section.

Mr. Herrick also has determined that, for each of the first five years the section is in effect, the public benefits anticipated as a result of enforcing the section will be the clarification and streamlining of the conversion application process under the Act, §1A. This should enhance the orderly administration of the Act and ensure that the purposes of the Act, as they relate to the conversion of prepaid funeral contracts from trust funded benefits to insurance funded benefits, are substantially fulfilled.

There will be no greater economic cost to persons who choose to apply for conversion under the Act, §1A. Proposed §25.25 should shorten the time period required to process and approve or reject an application by setting forth the requirements for applications and the standards against which those applications will be measured. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the section as proposed. §Comments on the proposal may be submitted to Brian R. Herrick, Assistant General Counsel, Texas Department of Banking, 2601 North Lamar Boulevard, Austin, Texas, 78705-4294.

The section is proposed under Texas Civil Statutes, Article 548b, §2, which authorizes the Department to prescribe reasonable rules and regulations concerning all matters incidental to the enforcement and orderly administration of Article 548b

Texas Civil Statutes, Article 548b is affected by the newly proposed §25. 25.

*§25.25. Conversion From Trust to Insurance Funded Benefits.*

(a) Purpose. Existing prepaid funeral contracts that utilize trust funded prepaid funeral benefits may be converted to an insurance funded prepaid funeral benefits arrangement pursuant to the Act, §1A(d). Application for conversion must be made on forms acceptable to the Department that meet the requirements of the Act and this section.

(b) Definitions. The following words and terms used in this section shall have the following meanings, unless otherwise defined herein or unless the context clearly indicates otherwise:

(1) Applicant–A permit holder under the Act who files an application with the Department to convert its trust funded prepaid funeral benefits under existing contracts to insurance funded prepaid funeral benefits.

(2) Cash surrender value–The net amount due the policy owner from the insurer upon surrender of an insurance policy.

(3) Commission, allowance, or load–Any commission or other compensation, expense load, premium expense, administrative charge or expense, policy fees, or other fee or expense paid to a Texas Department of Insurance licensed agent associated with or occurring by reason of the sale, issuance, lapse, surrender, or redemption of an insurance policy in connection with the conversion of any trust funded prepaid funeral contract to insurance funded benefits.

(4) Insurance policy–A life insurance policy or annuity contract.

(5) Post-conversion permit holder–The permit holder who will hold, administer, and assume responsibility for the delivery of the funeral service or merchandise or payment of the funeral provider, as the case may be, under the prepaid funeral contracts after conversion to insurance funding.

(6) Required reserves–The reserve liabilities for all outstanding life insurance policies and annuity contracts valued or calculated pursuant to actuarial standards and statutory accounting standards not inconsistent with the Texas Insurance Code.

(7) TDI–The Texas Department of Insurance.

(c) Applications.

(1) When applying for permission to convert trust funded benefits under existing prepaid funeral contracts to insurance funded benefits, an applicant must, at a minimum:

(A) hold a valid permit issued by the Department under the Act;

(B) be in good standing with the Department;

(C) submit a completed conversion application to the Special Audits Division of the Department; and

(D) as of its most recent examination by the Department, not have been found to be in violation of any applicable laws or regulations, or to have any other deficiencies of any significance, which have not been remedied or corrected to the satisfaction of the Department.

(2) The Department may, if it deems it necessary to protection the interests of the prepaid funeral contract purchasers, conduct an examination of the applicant within 45 days of the date the application is accepted by the Department for filing.

(3) Each application for conversion must include:

(A) a copy of a letter from an insurance company authorized to do business in Texas to the applicant that sets forth the insurance company's agreement to issue insurance policies to convert the prepaid funeral contracts from trust funded benefits to insurance funded benefits;

(B) a copy of the written commitment to the Commissioner containing the agreement between or among the insurance company, the applicant, and the post-conversion permit holder regarding the transfer, receipt, and application of the trust funds upon conversion, which commitment must:

(i) include the full name of the agent or agents who will be receiving any commission, allowance, or load and their respective TDI license numbers, if applicable; and

(ii) require that a copy of each insurance policy issued be furnished to the owner of the insurance policy and that a copy be made available to the respective prepaid funeral contract purchasers upon request, in the event they are not the owners of the policies;

(C) a pre-conversion summary of the individual prepaid funeral contracts, which must include, at a minimum, the following information (as of a date within 30 days of the date of the application), as well as aggregated totals for each category of information, if appropriate:

(i) purchaser's name and, if available, date of birth;

(ii) date of execution of the prepaid funeral contract;

(iii) face amount;

(iv) amount paid in and amount left owing;

(v) accumulated earnings;

(vi) amount due the prepaid funeral contract purchaser upon cancellation and the amount due the applicant upon death of the prepaid funeral contract purchaser, assuming death or cancellation were to occur on or about the date of the application; and

(vii) amount retained by the applicant under the Act, §5(a)(1);

(D) a post-conversion summary of the individual prepaid funeral contracts, which must include, at a minimum, the following information (as of the same date as the pre-conversion summary), as well as aggregated totals for each category of information, if appropriate:

(i) insured's or annuitant's name;

(ii) original prepaid funeral contract amount;

(iii) amount paid in;

(iv) amount applied to the purchase of the insurance policy;

(v) initial cash surrender value and initial death benefit under the insurance policy; and

(vi) amount retained by the applicant under the Act, §5(a)(1);

(E) a copy of the insurance policy approved by TDI showing the approval stamp of TDI, or evidence that the policy is deemed to have been approved or exempt from approval;

(F) a copy of the proposed negative response notification letter to the prepaid funeral contract purchasers from the applicant containing a statement explaining the purchaser has 60 days to file a written request with the Department to have the contract converted back to trust funded benefits;

(G) unless otherwise waived by the Commissioner upon a showing of good cause, current year-to-date financial statements for the post-conversion permit holder and insurance company (dated no more than six months prior to the date of the application) and an actuarial certification certifying that the reserves to be held by the insurance company with respect to the conversion will be adequate to pay claims as they become due;

(H) a copy of the insurance company's most recent actuarial certification, dated no more than one year prior the date of application;

(I) a copy of the proposed notification letter from the insurance company to the prepaid funeral contract purchasers regarding the conversion;

(J) a statement defining the insurance policy commission, allowance, or load, including the percentage and dollar amount of be the commission, allowance, or load, the time at which it is to imposed, and how the commission, allowance, or load will be distributed;

(K) a copy of the form of assignment, if any, to be used in assigning insurance policy rights or proceeds to the post-conversion permit holder;

(L) the conversion application fee prescribed in §25.23 of this title (relating to Application Fees); and

(M) a letter from an actuary, certified public accountant, or an attorney rendering an opinion as to whether, in the case of life insurance, the policies issued will qualify as life insurance for purposes of Internal Revenue Code, §7702, if the owner of the insurance policy will be the prepaid funeral contract purchaser.

(d) Standards for Approval of Application.

(1) An application for conversion will be approved by the Commissioner if, in the Commissioner's opinion, the rights and interests of the prepaid funeral contract purchasers under the insurance funded benefits arrangement will be safeguarded to the same degree as or to a greater degree than provided under the trust funded benefits arrangement. An application may be approved without the necessity of a hearing.

(2) In order for insurance funded benefits under an application for conversion to be considered to safeguard the rights and interests of the prepaid fu-

neral contract purchasers to the same degree as or a greater degree than the trust funded benefits, the insurance benefits must comply with this subsection.

(A) Unless otherwise permitted by the Commissioner upon a showing of good cause, the insurance funded benefits arrangement must apply to all of the applicant's trust funded prepaid funeral contract purchasers, as of the date of the application, and the insurance policy must provide each prepaid funeral contract purchaser with an initial cash surrender value or cancellation benefit that is greater than or equal to the cancellation benefit provided for under the trust funded benefits arrangement. In addition, the insurance company is responsible for maintaining adequate reserves for cancellations.

(B) The transfer of the trust funds to the insurance company must include the full sum required to be deposited as trust principal by the applicant pursuant to the Act under the trust funded prepaid funeral contracts proposed for conversion, plus all net earnings accumulated with respect thereto, as of the transfer date. No commission, allowance, or load may be deducted from the trust funds transferred pursuant to the conversion application.

(C) No provision in the insurance policy may provide or allow for contesting coverage, limited death benefits in the case of suicide, or make reference to a physical examination, or any other provision that would operate as an exclusion, limitation, or condition, other than submittal of proof of death or surrender of the policy, upon the funding, at maturity, or cancellation, as the case may be, of the original trust funded prepaid funeral contract or the benefits thereof.

(D) The death benefit under the insurance policy at all times must be no less than the death benefit prior to conversion.

(E) The insurance company must demonstrate that, in the previous seven years, the average death benefit growth under the same or substantially similar insurance policies issued by the insurance company to fund prepaid funeral contracts has been at least 3.0% per annum. If the insurance company cannot so demonstrate, then the insurance policy must provide for guaranteed growth of the death benefit of no less than 2.0% per annum compounded annually beginning in the first year of the policy.

(F) The post-conversion permit holder is responsible for payment of all death and cancellation claims in accordance with the provisions of the Act.

(G) The post-conversion permit holder must have a current valid permit issued by the Department under the Act, and must be in good standing with the Department.

(H) The post-conversion permit holder must have been examined by the Department within the 24-month period immediately preceding the date of the application and not have been found to be in violation of any applicable laws or regulations, or to have any other deficiencies of any significance, which have not been remedied or corrected to the satisfaction of the Department. If the post-conversion permit holder has not been examined by the Department within such time period, the Department may, if it deems necessary, conduct an examination of the post-conversion permit holder within 45 days of the date the application is accepted for filing or waive this requirement.

(I) The insurance company must be a member of the Texas Life, Accident, Health, and Hospital Service Insurance Guaranty Association.

(J) Any life insurance policy issued on any individual must be for an amount not less than the amount of principal and interest transferred for that individual to the insurance company, and any supplemental life insurance policy issued to cover the unfunded portion of the contract must have a face amount equal to or greater than the unfunded principal balance. No credit or reduction may be made for interest earned or accrued on the paid in principal balance.

(3) The applicant must demonstrate compliance with the Act, §5B for the previous year, and may not convert prepaid funeral contracts that are presumed abandoned under §5B. Any prepaid funeral contracts presumed to have been abandoned and the funds attributable to such contracts must be reported and delivered to the Texas State Treasurer in accordance with Texas Property Code, Chapter 74.

(e) Post-Conversion Summary. The post-conversion permit holder must submit to the Department, within 90 days of the date of transfer of the trust funds as authorized by the Commissioner's order, a post-conversion summary of the individual prepaid funeral contracts as of the conversion date, which must include, at a minimum, the following information, as well as aggregated totals for each category of information, if appropriate:

(1) insured's or annuitant's name;

(2) the original prepaid funeral contract amount;

(3) amount paid in;

(4) amount applied to the purchase of the insurance policy;

(5) initial cash surrender value and initial death benefit under the insurance policy; and

(6) amount retained by the applicant under the Act, §5(a)(1).

(f) Records. The applicant shall relinquish to the post-conversion permit holder the individual prepaid funeral contract ledgers reflecting the amount paid and the amount left owing on the prepaid funeral contract, if any. The post conversion permit holder shall be responsible for maintaining such ledgers to reflect the principal balance of the converted contracts as well as any outstanding balances.

(g) Hearings. The Commissioner may order a hearing on an application. A hearing, if ordered, shall be conducted pursuant to the Department's rules governing hearings. The applicant shall have the burden to demonstrate the existence of all factors necessary to entitle the applicant to convert to insurance funded benefits from trust funded benefits by a preponderance of the evidence.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 24, 1995.

TRD-9509301 Everette D. Jobe
General Counsel
Banking Department of Texas

Earliest possible date of adoption: September 1, 1995

For further information, please call: (512) 475-1300

# TITLE 25. HEALTH SERVICES

## Part II. Texas Department of Mental Health and Mental Retardation

### Chapter 409. Medicaid Programs

### Subchapter A. General Reimbursement Methodology for All Medical Assistance Programs

- **25 TAC §§409.1, 409.8-408.19**

The Texas Department of Mental Health and Mental Retardation (TDMHMR) proposes an amendment to §409.1 and new §§409.8-409.19 of Chapter 409, Subchapter A, concerning general reimbursement methodology for all medical assistance programs.

The purpose of the amendment and new sections is to establish cost determination rules that are consistent with the rules of the Texas Department of Human Services (TDHS), provide explicit guidelines for auditors, provide specific instructions concerning cost reporting, and provide guidelines in areas such as documentation and allocation methods. Similar provisions have been proposed contemporaneously in this issue of the *Texas Register* by TDHS for those Medicaid programs for which that agency is the state operating agency.

Don Green, chief financial officer, has determined that for each year of the first five-year period the amendment and new sections are in effect there will be no significant fiscal impact as a result of implementing the provisions as proposed. There is no anticipated local economic impact.

Ernest McKenney, director, Medicaid Administration, has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be having a single set of guidelines for all Medicaid programs, whether administered by TDMHMR or TDHS, to facilitate financial accountability relating to service delivery. There is no anticipated economic cost to persons who are required to comply with the proposed sections. There will be no effect on small businesses.

Questions about the content of the proposal may be directed to Ernest McKenney at (512) 323-3855. Written comments on the proposal may be sent to Linda Logan, director, Policy Development, Texas Department of Mental Health and Mental Retardation, P.O. Box 12668, Austin, Texas 78711-2668, within 30 days of publication.

Copies of the submission may be obtained by contacting a local TDHS field office. Copies also may be obtained by writing to the Texas Department of Mental Health and Mental Retardation, Office of Policy Development, P.O. Box 12668, Austin, Texas 78711-2668, or by calling (512) 206-4516.

A public hearing will be held at 3:00 p.m. on August 16, 1995, in the TDMHMR Central Office auditorium at 909 West 45th Street in Austin to accept oral and written testimony concerning the proposed amendment and new sections. The hearing will be held jointly with TDHS; testimony will be accepted at the same time concerning similar provisions proposed by TDHS rules relating to those Medicaid programs for which TDHS is the state operating agency. If interpreters for the hearing impaired are required, please notify Laura Thomas at least 72 hours prior to the hearing by calling (512) 206-4516.

The sections were previously proposed in the December 30, 1994, issue of the *Texas Register* (19 TexReg 10421). A public hearing was held on January 10, 1995, at the TDMHMR Central Office in Austin, Texas, to accept oral and written testimony on these rule proposals and on proposed changes to rules governing ICF/MR contained in Chapter 406 of this title. The hearing was held jointly with TDHS, which contemporaneously proposed similar provisions for Medicaid programs for which TDHS is the state operating agency. Written and/or oral testimony was provided by Bill McIlhany, Texas Home Health, Austin; Carole Smith, Private Providers Association of Texas, Austin; Tom Plowman, the Texas Health Care Association, Austin; Steve Kitchen, Kitchen and Associates, Austin; Randy Donaldson, Educare Community Living, Austin; Dennis Henegar, Educare, Austin; and Anita Bradberry, Texas Association for Home Care.

During the public comment period written comments were also received from Barry Waller, Dallas County Mental Health and Mental Retardation Center, Dallas; Spencer McClure, Texas Council of Community Mental Health and Mental Retardation Centers; Rex Wisner, B & W Development Centers, Inc., Graham; Michael Nash, Life Management Center for MH/MR Services, El Paso; and Steve Wirth, Concept Six, Austin.

The proposals were automatically withdrawn on June 30, 1995. The current proposal includes previous provisions and additional changes made in response to public comment, which are as follows:

Concerning Chapter 409, Subchapter A, the following changes would be proposed: A number of modifications to terminology would be made for clarity, including changing most references to "the department" to "the Texas Department of Mental Health and Mental Retardation" or "TDMHMR"; the word "contracted" would be added to references to client care and services in several provisions; references to "all department Medicaid programs" would be changed to "all other programs" in a number of provisions; and citations throughout the rules are updated or corrected as appropriate. A number of minor clarifying changes to language are made.

In §409.8(a), language would be added to specifically denote the sections of the rule containing information concerning completing and submitting cost reports. In §409.8(b), language would be added to clarify the intent that the terms "Texas Department of Mental Health and Mental Retardation" and "TDMHMR" mean the department or its designee.

In §409.9(a), the term "cost report" would be changed to "database" to clarify that costs that are "unallowable" are not included in the database used to determine reimbursement, but that such costs are not prohibited. In subsection (d), language would be added to clarify that travel costs for state-sponsored cost report training and fees for contracted cost report preparers to attend are allowable. In subsection (e), a minor clarification would be made with regard to generally accepted accounting principles (GAAP). In subsection (g), the explanation of unallowable costs would be expanded to include both reference to §409.10 and §409.19. In subsection (i)(5), it would be clarified that an exception to the general rules governing related organizations may in some cases take into account a determination made by Medicare that a related party situation does not exist. In subsection (i)(5)(B) , the term "substantial" would be replaced by the term "majority" in defining the extent of the business activity that a potentially related organization must conduct with others to demonstrate that its activity with the contracted provider would be undertaken in an open and competitive business atmosphere. In subsection (j)(1)(E), it would be clarified that the submittal a cost report by a new contracted provider without an approved allocation method will be considered a failure to file a completed cost report. In subsection (j)(3), it would be clarified that when building space is shared, shared costs should be allocated using reasonable quantifiable methods. The example illustrating principles of equivalent units in subsection (j)(4)(A) would be modified to be consistent with programs contracted by TDMHMR, i.e., ICF/MR, rather than nursing facilities. Language would be modified in subsection (j)(4)(E) to clarify that the determination of reimbursement is based on cost data.

In §409.10(a), reference would be added to §409.19. Language in subsections (b)(1)(A) and (2)(A) have been revised to clarify that compensation includes wages, salaries, payroll taxes, insurance, and fringe benefits. In subsection (b)(1)(A)(i), it would be clarified that for purposes of awarding bonuses, part-time employees can be considered a different classification type from full-time employees. In subsection (b)(2)(A)(ii), the word "facility" would be changed to "contracted provider." In subsection (b)(2) (B), the term "related parties" would be added. In subsection (b)(2)(C)(i)(II), it would be clarified that costs attributable to a financial audit conducted with a single audit are allowable if the cost of the financial audit can be identified separately. In subsection (b)(2)(C)(ii) a clarification would be made concerning allowable legal fees. In subsection (b)(7), provisions relating to depreciation and amortization are clarified, and it would be clarified that certain changes apply to purchases made after the beginning of the provider's fiscal year 1996. In subsection (b)(7)(C)(i), the amount to be added to the lease ceiling for luxury vehicles on an annual basis is increased from 1.5% to 2.0%, effective January 1, 1997. In subsection (b)(10)(B), language would be added concerning qualifying criteria for providing self-insurance plans. In subsection (b)(10)(B)(i), it would be clarified that compensation to employees who have been injured on the job is

an allowable cost. In subsection (b)(10)(G)(ii)(I) and (II), the term "lending institution" would be expanded to include "or other lending party." In subsection (b)(12)(A)(v), reference to nursing facility aide training would be deleted. In subsection (b)(12)(B)(iii)(II), provisions concerning necessary documentation to justify travel by private aircraft are added. Subsection (b)(13)(A)(ii) would be modified to allow yellow page telephone directory listings of up to one-eighth page in the provider's service area. Subsection (b)(15)(D) would be modified to address the allowability of nonroutine operating expenses. Subsections (b)(16)(A) and (B) discuss allowable in-kind donations in detail. Subsection (b)(17)(D) discusses in detail aspects of startup costs. Subsection (b)(17)(I)(iii) would be revised to indicate that travel to attend specified state government meetings is an allowable cost. In §409.10(b)(J), language would be added to clarify that reasonable staff costs to attend meetings with state agency staff and to testify at state agency held public hearings and advisory committee meetings regarding these programs are allowable. Subsection (b)(17)(K) would be revised to specify Medicare Part A and B ancillary services. Subsection (b)(17)(L) was deleted and language was added to §409. 10(b)(16) to allow the inclusion of in-kind donations as allowable costs. Subsection (b)(18) would be revised to provide that if another payor is not available, the costs in question may be allowable if documentation demonstrates that the provider of services was not accessible.

In §409.12(b)(2)(B)(i), language would be added that defines "week" for purposes of time studies. In subsection (b)(2)(B)(iii), language would be added concerning necessary documentation justifying private aircraft travel expenses. In subsection (b)(3), the requirements concerning cost report and methodology training are clarified.

In §409.12(b)(3), language would be added clarifying that not all persons involved in the preparation of the cost report must sign the certification page, although a responsible party with direct knowledge of the preparation of the cost report must sign the certification page.

Minor language changes are made in §§409.13-409.18. New §409.19, which describes program-specific requirements, has not been previously proposed.

The amendment and new sections are proposed under the Texas Health and Safety Code, Title 7, §532.015, which provides the Texas Board of Mental Health and Mental Retardation with rulemaking powers; and under the provisions of Texas Civil Statutes, Article 4413(502) §16, which provide the Health and Human Services Commission with the authority to administer federal medical assistance funds.

The proposal implements the Texas Human Resources Code §22.002 and §§32.001-32.040 and Texas Civil Statutes, Article 4413(502).

*§409.1. General Specifications and Definitions.*

(a) **Specifications.** The Texas Department of Mental Health and Mental Retardation **(TDMHMR)** [(TXMHMR)] reimburses Texas Medicaid contracted providers for medical assistance provided to Medicaid recipients **in the following programs: Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR), Case Management for Persons with Severe and Persistent Mental Illness, Case Management for Persons with Mental Retardation or Related Conditions, Home and Community-Based Services, Home and Community-Based Services-OBRA, Diagnostic Services for Persons with Potential of Mental Retardation, and Rehabilitative Services for Persons with Mental Illness.** [The Texas Mental Health and Mental Retardation Board determines perspective uniform reimbursement rates at least annually, unless the board decides otherwise. Whenever the term Texas Department of Mental Health and Mental Retardation (TXMHMR) occurs it means the Texas Department of Mental Health and Mental Retardation (TXMHMR) or its designee.]

**(b) Definitions. The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:**

(1) Department-The Texas Department of Mental Health or Mental Retardation or its designee.

(2) Board-The Texas Board of Mental Health and Mental Retardation.

*§409.8. Introduction.*

(a) The Texas Board of Mental Health and Mental Retardation determines prospective uniform reimbursement rates at least annually, unless the board decides otherwise. Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in §§409.2-409.7 of this chapter (relating to Medicaid Programs). Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §§409.8-409.19 of this chapter (relating to Medicaid Programs).

(b) The Texas Department of Mental Health and Mental Retardation (TDMHMR) reimburses providers for contracted client care according to the reimbursement methodologies for each program. Non-Medicaid, statewide, uniform reimbursements and reimbursement ceilings are approved by the Texas Board of Mental Health and Mental Retardation. The board recommends for approval to the Texas Health and Human Services Commission (HHSC) medical assistance or Medicaid reimbursements that are uniform by class. In Medicaid programs where reimbursements are contractor-specific, the board recommends for approval to the HHSC the reimbursement parameter dollar amounts, e.g., ceilings, floors, or program reimbursement formula limits. Medicaid reimbursement methodology rules are developed and recommended for approval by the board to the HHSC. The HHSC has oversight authority with respect to the state's Medicaid rules. Whenever the terms "Texas Department of Mental Health and Mental Retardation" or "TDMHMR" occur, they each mean the Texas Department of Mental Health and Mental Retardation or its designee.

(1) Objective of cost determination process. The objective of the cost determination process is to define direct and indirect costs which are allowable and, therefore, may be considered for use in the overall reimbursement determination process. The cost determination process seeks to collect accurate financial and other statistical data which constitute the foundation upon which reimbursements are determined.

(A) Cost-reporting. In order to ensure adequate financial and statistical information upon which to base reimbursement, TDMHMR requires that each contracted provider submit a periodic cost report or supplemental report. It is the responsibility of the provider to submit accurate and complete information in accordance with all pertinent TDMHMR cost reporting rules and cost report instructions, on the cost report and any supplemental reports required by TDMHMR.

(B) Pro forma costing. When historical costs are unavailable, such as in the case of a new program, reimbursement may be based on a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and estimating the basic types and costs of products and services necessary to deliver services meeting federal and state requirements.

(2) Relationship between cost determination and reimbursement determination processes. The cost determination process seeks to evaluate individual cost items of providers to determine their allowability and to determine whether individual cost reports are of reasonable accuracy for potential use in reimbursement determination. The reimbursement determination process takes the evaluation of allowable costs one step further by comparing allowable costs across providers to identify those levels of cost, either for individual cost items or groups of cost items, which must be incurred by efficient and economic providers of services meeting all state and federal standards. Thus, all costs allowed in the cost determination process may not nec-

essarily be used in the reimbursement determination process. The basic objective of the reimbursement methodologies employed by TDMHMR is to facilitate and balance the broader objectives of the programs administered by the agency by:

(A) promoting reasonable access for eligible clients to services that meet federal and state quality standards via contracting with an adequate number of qualified providers; and

(B) expending taxpayer dollars in a reasonable and prudent manner so that eligible clients are served at the lowest cost to taxpayers consistent with state and federal laws, standards and regulations, and with program objectives.

(c) For the completion and submittal of cost reports covering providers' fiscal year ending in calendar year 1995, the following sections of this subchapter will not apply: §409.9 of this title (relating to General Principles of Allowable and Unallowable Costs), §409.10 of this title (relating to Specifications for Allowable and Unallowable Costs), §409.11 of this title (relating to Revenues), and §409. 12 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

*§409.9. General Principles of Allowable and Unallowable Costs.*

(a) Allowable and unallowable costs. Allowable and unallowable costs, both direct and indirect identify expenses which are reasonable and necessary to provide contracted client care and are consistent with federal and state laws and regulations. If a particular type of expense is classified as unallowable, then the classification means only that the expense will not be included in the database for reimbursement determination purposes because the expense is not considered reasonable and/or necessary. The classification does not mean that individual contracted providers may not make the expenditure. The description of allowable and unallowable costs is designed to be a general guide and to clarify certain key expense areas. This description is not comprehensive, and the failure to identify a particular cost does not necessarily mean that the cost is an allowable or unallowable cost.

(b) Cost-reporting process. The primary objective of the cost-reporting process is to provide a basis for determining appropriate reimbursement to contracted providers. To achieve this objective, the reimbursement determination process uses allowable cost information reported on cost reports or other surveys. The cost report collects actual allowable costs and other financial and statistical information, as required. Costs may not be imputed and reported on the cost report when no costs were actually incurred (except as stated in §409.10(b)(16)(i)(I) of this title (relating to Specifications for Allowable and Unallowable Costs) or when documentation does not exist for costs even if they were actually incurred during the reporting period.

(c) Accurate cost reporting. 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 accordance with allowable and unallowable cost guidelines in this section and in §409.10 of this title (relating to Specifications for Allowable and Unallowable Costs), revenue reporting guidelines in §409.11 of this title (relating to Revenues), cost report instructions, and applicable program rules. Reporting all allowable costs on the cost report is the responsibility of the contracted provider. TDMHMR is not responsible for the contracted provider's failure to report allowable costs; however, in an effort to collect reliable, accurate, and verifiable financial and statistical data, TDMHMR is responsible for providing cost report training, general and/or specific cost report instructions, and technical assistance to providers. Furthermore, if unreported and/or understated allowable costs are discovered during the course of an audit desk review or field audit, those allowable costs will be included on the cost report or brought to the attention of the provider to correct by submitting an amended cost report.

(d) Cost report training. TDMHMR is responsible for conducting, at no charge to the provider, comprehensive cost report training for each contracted program. Beginning with the 1996 cost reports, it is the responsibility of the provider to ensure that each preparer signing the Cost Report Methodology Certification has attended cost report training conducted by TDMHMR or its designee. Preparers can be employees of the provider or persons who have been contracted by the provider for the purpose of cost report preparation. Preparers must attend cost report training for each program for which a cost report is submitted. Preparers must attend cost report training for two consecutive years, after which they are required to attend training on at least a biennial basis. A copy of the most recent cost report training certificate for each preparer of the cost report must be submitted with each cost report. Failure to file a completed cost report signed by preparers who have attended the required cost report training constitutes an administrative contract violation. Refer to §409.12 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures) and §409.18 of this title (relating to Administrative Contract Violations). Travel costs to attend the state-sponsored cost report training are allowable within the travel limits specified in §409.10(b)(12) of this title (relating to Specifications for Allowable and Unallowable Costs). Contracted preparer's fees to attend state-sponsored cost report training are also allowable.

(e) Generally accepted accounting principles. Except as otherwise specified by the cost determination process rules of this chapter, cost report instructions, or policy clarifications, cost reports should be prepared consistent with generally accepted accounting principles (GAAP) which are those principles approved by the American Institute of Certified Public Accountants (AICPA). Internal Revenue Service (IRS) laws and regulations do not necessarily apply in the preparation of the cost report. In cases in which cost reporting rules differ from GAAP, IRS, or other authorities, TDMHMR rules take precedence for provider cost-reporting purposes.

(f) Allowable costs. Allowable costs are expenses, both direct and indirect, that are reasonable and necessary, as defined in paragraphs (1) and (2) of this subsection, and which meet the requirements as specified in subsections (i), (j), and (k) of this section, in the normal conduct of operations to provide contracted client services meeting all pertinent state and federal requirements. Only allowable costs are included in the reimbursement determination process.

(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:

(A) 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

(B) the action that a prudent person would take in similar circumstances, considering the person's responsibilities to the public, the government, employees, clients, shareholders, and members, and the fulfillment of the purpose for which the business was organized.

(2) "Necessary" refers to the relationship of the cost, direct or indirect, incurred by a provider to the provision of client care. Necessary costs are direct and indirect costs that are appropriate in devel-

oping 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:

(A) the expenditure was not for personal or other activities not directly or indirectly related to the provision of contracted services;

(B) the cost does not appear as a specific unallowable cost in §409.10 of this title (relating to Specifications for Allowable and Unallowable Costs);

(C) 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 contracted client health, safety, or general well-being;

(D) 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;

(E) 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;

(F) the costs are net of all applicable credits;

(G) allocated costs of each program are adequately substantiated; and

(H) the costs are not prohibited under other pertinent federal, state, or local laws or regulations.

(3) Direct costs are those costs which are incurred by a provider which 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.

(4) Indirect costs are those shared costs which benefit, or contribute to, the operation of providing contracted services, other business components, or the overall entity with which TDMHMR has contracted. These costs could include, but are not limited to, administration salaries and nonlabor costs, building costs, insurance expense, and interest expense. Central office and/or home office administrative expenses are considered indirect costs. Indirect costs must be allocated, directly or as a pool of costs, across those business components sharing in the benefits of those costs.

(g) Unallowable costs. Unallowable costs are expenses that are not reasonable or necessary, according to the criteria specified in subsection (f)(1) and (2) of this section and which do not meet the requirements as specified in subsections (i), (j), and (k) of this section or which are specifically enumerated in §409. 10 of this title (relating to Specifications for Allowable and Unallowable Costs) or §409.19 of this title (relating to Program-Specific Allowable and Unallowable Costs). Placement as an allowable cost on a cost report of a cost which has been determined to be unallowable may constitute an administrative contract violation and may constitute fraud. (Refer to Chapter 409, Subchapter C of this title (relating to Statutory Bases) for the statutory basis for Medicaid fraud and §409.13(a) of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports)). In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §409.18 of this title (relating to Administrative Contract Violations) for all other programs.

(h) Other financial and statistical data. The primary purpose of the cost report is to collect allowable costs to be used as a basis for reimbursement determination. In addition, providers may be required on cost reports to provide information in addition to allowable costs to support allowable costs, such as wage surveys, workers' compensation surveys, or other statistical and financial information. Additional data requested may include, when specified and in the appropriate section or line number specified, costs incurred by the provider which are unallowable costs. All information, including other financial and statistical data, shown on a cost report is subject to the documentation and verification procedures required for an audit desk review and/or field audit. Inaccuracy in providing, or failure to provide, this information may constitute an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §409.18 of this title (relating to Administrative Contract Violations) for all other programs.

(i) Related-Party Transactions.

(1) In determining whether a contracted provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. "Related to a contracted provider" means that the contracted provider to a significant extent is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, equipment, facilities, or supplies. Common ownership exists if an individual or individuals possess any ownership or equity in the contracted provider and the institution or organization serving the contracted provider. 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. If the elements of common ownership or control are not present in both organizations, then the organizations are deemed not to be related to each other. The existence of an immediate family relationship will create an irrebuttable 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, sister-in-law, brother-in-law, son-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

(I) first cousins.

(2) A determination as to whether an individual (or individuals) or organization possesses ownership or equity

in the contracted provider organization and the supplying organization, so as to consider the organizations related by common ownership, will be made on the basis of the facts and circumstances in each case. This rule applies whether the contracted provider organization or supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or nonprofit. In the case of a nonprofit organization, ownership or equity interest will be determined by reference to the interest in the assets of the organization, e.g., a reversionary interest provided for in the articles of incorporation of a nonprofit corporation.

(3) The term control includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise The facts and circumstances in each case must be examined to ascertain whether legal or effective control exists. Since a determination made in a specific case represents a conclusion based on the entire body of facts and circumstances involved, such determination should not be used as a precedent in other cases unless the facts and circumstances are substantially the same. Organizations, whether proprietary or nonprofit, are considered to be related through control to their directors in common

(4) Costs applicable to services, equipment, facilities, and supplies furnished to the contracted provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, the cost must not exceed the price of comparable services, equipment, facilities, or supplies that could be purchased or leased elsewhere. The purpose of this principle is twofold: to avoid the payment of a profit factor to the contracted provider through the related organization (whether related by common ownership or control), and to avoid payment of artificially inflated costs which may be generated from less than arm's-length bargaining. The related organization's costs include all reasonable costs, direct and indirect, incurred in the furnishing of services, equipment, facilities, and supplies to the provider. The intent is to treat the costs incurred by the supplier as if they were incurred by the contracted provider itself. Therefore, if a cost would be unallowable if incurred by the contracted provider itself, it would be similarly unallowable to the related organization. The principles of reimbursement of contracted provider costs described throughout this title will generally be followed in determining the reasonableness and allowability of the related organization's costs, where application of a principle in a nonprovider entity would be clearly inappropriate.

(5) An exception is provided to the general rule applicable to related organizations. The exception applies if the contracted provider demonstrates on each cost report by convincing evidence to the satisfaction of TDMHMR that certain criteria have been met. If all of the conditions of this exception are met, then the charges by the supplier to the contracted provider for such services, equipment, facilities, or supplies are allowable costs. If Medicare has made a determination that a related-party situation does not exist or that an exception to the related party definition was granted, TDMHMR will review the determination made by Medicare to determine if it is applicable to the current situation of the contracted provider and in compliance with this subsection. In order to have the Medicare determination considered for approval by the department, a copy of the applicable Medicare determination must accompany each affected cost report submitted to the department, along with evidence supporting the Medicare determination for the current cost report period. If the exception granted by Medicare is no longer applicable due to changes in circumstances of the contracted provider or because the circumstances do not apply to the contracted provider, the department may choose not to accept the Medicare determination. The contracted provider must demonstrate that the following criteria have been met.

(A) The supplying organization is a bona fide separate organization. This means that the supplier is a separate sole proprietorship, partnership, joint venture, association, or corporation and not merely an operating division of the contracted provider organization.

(B) A majority of the supplying organization's business activity of the type carried on with the contracted provider is transacted with other organizations not related to the contracted provider and the supplier by common ownership or control and there is an open, competitive market for the type of services, equipment, facilities, or supplies furnished by the organization. In determining whether the activities are of similar type, it is important also to consider the scope of the activity. The requirement that there be an open, competitive market is merely intended to assure that the item supplied has a readily discernible price that is established through arm's-length bargaining by well-informed buyers and sellers.

(C) The services, equipment, facilities, or supplies are those that are commonly obtained by entities such as the contracted provider from other organizations and are not a basic element of contracted client care ordinarily furnished directly to clients by such entities. This requirement means that entities such as the contracted provider typically obtain the services, equipment, facilities, or supplies from outside sources, rather than producing them internally.

(D) The charge to the contracted provider is in line with the charge of such services, equipment, facilities, or supplies in the open, competitive market and no more than the charge made under comparable circumstances to others by the organization for such services, equipment, facilities, or supplies.

(6) Disclosure of all related-party information on the cost report is required for all costs reported by the contracted provider, including related-party transactions occurring at any level in the provider's organization (e.g., the central office level, and the individual contracted provider level). The contracted provider must make available, upon request, adequate documentation to support the costs incurred by the related party. Such documentation must include an identification of the related person or organization's total costs, the basis of allocation of direct and indirect costs to the contracted provider, and other business entities served. If a contracted provider fails to provide adequate documentation to substantiate the cost to the related person or organization, then the reported cost is unallowable. For further guidelines regarding adequate documentation, refer to §409.12(b)(2) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(7) When calculating the cost to the related organization, the cost determination guidelines specified in §409.9 and §409.10 of this title (relating to General Principles of Allowable and Unallowable Costs and Specifications for Allowable and Unallowable Costs) apply.

(j) Cost Allocation. Direct costing must be used whenever reasonably possible. Direct costing means that allowable costs, direct or indirect, incurred for the benefit of, or directly attributable to, a specific business component must be directly charged to that particular business component. In the case of direct costs as defined in subsection (f)(3) of this subsection, direct costing is required. In the case of indirect costs as defined in subsection (f)(4) of this section, it is necessary to allocate these costs either directly or as a pool of costs across those business components sharing in the benefits.

(1) 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.

(A) The allocation method should be a reasonable reflection of the actual business operations. Allocation methods that do not reasonably reflect the actual business operations and resources expended towards each unique business entity are not acceptable. Allocated costs are adjusted if TDMHMR considers the allocation method to be unreasonable. An indirect allocation method approved by some other department, program, or governmental entity is not automatically approved by TDMHMR for cost-reporting purposes.

(B) TDMHMR or its designee reviews each cost-reporting allocation method on a case-by-case basis in order to ensure that the reported costs fairly and reasonably represent the operations of the contracted provider. If in the course of an audit it is determined that an existing or approved allocation method does not fairly and reasonably represent the operations of the contracted provider, then an adjustment to the allocation method will be made consistent with subsection (f) (3) and (4) of this section. A contracted provider may request an informal review, and subsequently an appeal, of a decision concerning its allocation methods in accordance with §409.17 of this title (relating to Informal Reviews and Formal Appeals).

(C) 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.

(D) Any change in cost-reporting allocation methods from one year to the next must be fully disclosed by the contracted provider on its cost report, must be accompanied by a written explanation of the reasons and justification for such change, and must be accompanied by written prior approval from TDMHMR or its designee

(i) Requests for approval of a provider's change in cost-reporting allocation method must be received by TDMHMR or its designee prior to the end of the contracted provider's fiscal year. Requests for approval of allocation methods will not be acceptable as a basis for the extension of the cost report due date.

(ii) TDMHMR or its designee will forward its written decision to the contracted provider within 45 days of its receipt of the provider's original written request. If sufficient documentation is not provided by the provider to verify the acceptability of the allocation method, then TDMHMR may extend the decision time frame However, an extension of the due date of the cost report will not be granted. Written decisions made on or after the due date of the cost report will apply to the next year's cost report. A contracted provider may request an informal review, and subsequently an appeal, of a decision concerning its allocation methods in accordance with §409.17 of this title (relating to Informal Reviews and Formal Appeals).

(iii) Failure to disclose a change in an allocation method or failure to use the allocation method approved or required by TDMHMR or its designee may be considered an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §409.18 of this title (relating to Administrative Contract Violations) for all other programs.

(E) Any new contracted provider submitting its first cost report must have its cost-reporting allocation methods approved by TDMHMR or its designee prior to submitting its first cost report. submittal of a cost report for a new contracted provider without an approved allocation method is considered a failure to file a completed cost report in accordance with §409 12(b)(4)(c) of this title (General Reporting and Documentation Requirements, Methods, and Procedures.)

(i) Requests for approval of a new provider's cost-report allocation methods must be received by TDMHMR or its designee 60 days prior to the due date of the cost report. Requests for approval of allocation methods will not be acceptable as a basis for the extension of the cost report due date

(ii) TDMHMR or its designee will forward its written decision to the contracted provider within 45 days of its receipt of the provider's original written request. If sufficient documentation is not provided by the provider to verify the acceptability of the allocation method, then TDMHMR may extend the decision time frame. However, an extension of the due date of the cost report will not be granted. Written decisions made on or after the due date of the cost report will apply to the next year's cost report. A contracted provider may request an informal review, and subsequently an appeal, of a decision concerning its allocation methods in accordance with §409.17 of this title (relating to Informal Reviews and Formal Appeals).

(2) Cost-reporting methods for allocating costs must be clearly and completely documented in the contracted provider's workpapers, with details as to how pooled costs are allocated to each segment of the business entity, for both contracted and noncontracted programs.

(A) If a contracted provider has questions regarding the reasonableness of an allocation method, that contracted provider should request written approval from TDMHMR or its designee prior to submitting a cost report utilizing the allocation method in question Requests for approval must be received by TDMHMR or its designee prior to the end of the contracted provider's fiscal year. Requests for approval of allocation methods will not be acceptable as a basis for the extension of the cost report due date.

(B) TDMHMR or its designee will forward its written decision to the contracted provider within 45 days of its receipt of the original written request. If sufficient documentation is not provided by the provider to verify the acceptability of the allocation method, TDMHMR may extend the decision time frame. However, an extension of the due date of the cost report will not be granted. Written decisions made on or after the due date of the cost report will apply to the next year's cost report. A contracted provider may request an informal review, and subsequently an appeal, of a decision concerning its allocation methods in accordance with §409 17 of this title (relating to Informal Reviews and Formal Appeals).

(3) When a building is shared and the building usage is separate and distinct for each entity using the building, the building costs, such as rent, depreciation, utilities, maintenance, and insurance should be allocated based upon square footage and may not be allocated with other indirect costs as a pool of costs. When the same building space is shared by various entities, the shared building costs, such as rent, depreciation, utilities, maintenance, and insurance should be allocated using a reasonable method which reflects the actual usage, such as an allocation based on time in shared activity areas or meals served in shared dining and kitchen areas.

(4) Where costs are shared, are not directly chargeable, and are allocated as a pool of costs, the following allocation methods are acceptable for cost-reporting purposes.

(A) If all the business components of a contracted provider have equivalent units of equivalent service, indirect costs must be allocated based upon each business component's units of service. For example, if a provider had two Intermediate Care Facilities for the Mentally Retarded (ICFs-MR), indirect costs requiring allocation as a pool of costs must be allo-

cated based upon each ICF-MR's units of service, since the units of service are equivalent units and the services are equivalent services. If a provider had an ICF/MR and a Home and Community Based (HCS) program, indirect costs requiring allocation as a pool of costs could not be allocated based upon units of service because even though the units of service are equivalent units, the services are not equivalent services. If a provider operates an ICF-MR and a Community Services program for Mental Health and Mental Retardation, it could not use units of service to allocate those costs, since neither the units of service nor the services are equivalent.

(B) If all of a contracted provider's business components are labor-intensive without programmatic residential facility or residential building costs, the contracted provider must allocate its indirect costs requiring allocation as a pool of costs based either on each business component's pro rata share of salaries or labor costs or on a cost-to-cost basis.

(i) For cost-reporting cost allocation purposes, the term "salaries" includes wages paid to employees directly charged to the specific business component. The term "salaries" also includes fees paid to contracted individuals, excluding consultants, who perform services routinely performed by employees, which are directly charged to the specific business component. The term "salaries" does not include payroll taxes and employee benefits associated with the wages of employees.

(ii) For cost-reporting cost allocation purposes, the term "labor costs" includes salaries as defined in subparagraph (B)(i) of this paragraph, plus the payroll taxes and employee benefits associated with the wages of the employees.

(iii) The cost-to-cost method allocates costs based upon the percentage of each business component's directly-charged costs to the total directly-charged costs of all business components.

(C) If a contracted provider's business components are mixed, with some being labor-intensive and others having a programmatic residential or institutional component, the contracted provider must allocate its indirect costs requiring allocation as a pool of costs based upon the ratio of each business component's total costs less that business component's facility or building costs, as related to the contracted provider's total business component costs less facility or building costs for all the contracted provider's business components.

(D) In order to achieve a more accurate and representative reporting of costs than results from allocating indirect costs as a pool of costs, a provider may choose to allocate its indirect shared expenses on a functional basis. For example, costs of a central payroll operation could be allocated to all business components based on the number of checks issued; the costs of a central purchasing function could be allocated based on the dollar amount of purchases made or requisitions handled; payroll costs for an employee working across business components could be allocated based upon that employee's time sheets and/or a documented time study; food costs could be allocated based upon the number of meals served; transportation equipment costs could be allocated based upon mileage logs.

(E) Because the determination of reimbursement is based on cost data, allocation methods based upon revenue streams are inappropriate and unallowable.

(k) Net expenses. Net expenses are gross expenses less any purchase discounts or returns and allowances. Purchase discounts are cash discounts reducing the purchase price as a result of prompt payment, quantity purchases, or for other reasons. Purchase returns and allowances are reductions in expenses resulting from returned merchandise or merchandise which is damaged, lost or incorrectly billed. Only net expenses may be reported on the cost report. Expenses reported on the cost report must be adjusted for all such purchase discounts or returns and allowances.

*§409.10. Specifications for Allowable and Unallowable Costs.*

(a) Introduction. The following list of allowable and unallowable costs is not comprehensive but serves as a guide and clarifies certain key expense areas. If a particular type of expense is classified as unallowable for purposes of reporting on a cost report, it does not mean that individual contracted providers may not make such expenditures. Except where specific exceptions are noted, the allowability of all costs is subject to the general principles specified in §409.9 of this title (relating to General Principles of Allowable and Unallowable Costs). In addition, refer to §409.19 of this title (relating to Program-Specific Allowable and Unallowable Costs).

(1) Accounting and auditing fees. See subsection (b)(2)(C)(i) of this section.

(2) Advertising and public relations. See subsection (b)(13) of this section.

(3) Amortization expense. See subsection (b)(7) of this section.

(4) Bad debt expense. See subsection (b)(17)(M) of this section.

(5) Board of directors See subsection (b)(2)(E) of this section.

(6) Bonuses. See subsection (b)(1)(A)(i) of this section.

(7) Central office costs. See subsection (b)(4) of this section.

(8) Charity allowance. See subsection (b)(17)(N) of this section.

(9) Compensation of employees. See subsection (b)(1) of this section.

(10) Compensation of owners and related parties. See subsection (b)(2) of this subsection.

(11) Compensation of outside consultants See subsection (b)(2)(C) of this section.

(12) Courtesy allowance. See subsection (b)(17)(N) of this subsection.

(13) Depreciation expense. See subsection (b)(7) of this section.

(14) Donated revenues. See subsection (b)(15) of this section.

(15) Donated services, supplies, and assets. See subsection (b)(16) of this section.

(16) Dues or contributions to organizations. See subsection (b)(11) of this section.

(17) Employee relations expenses. See subsection (b)(17)(A) of this section.

(18) Employment-related taxes. See subsection (b)(9)(B) of this section.

(19) Endowment income. See subsection (b)(15) of this section.

(20) Expenses not related to contracted services. See subsection (b)(17)(H) of this section.

(21) Fines and penalties. See subsection (b)(17)(G) of this section.

(22) Franchise tax. See subsection (b)(9)(C) of this section.

(23) Finance charges. See subsection (b)(8)(E) of this section.

(24) Franchise fees. See subsection (b)(17)(C) of this section.

(25) Fringe benefits. See subsection (b)(1)(A)(iii) of this section.

(26) Fundraising activities. See subsection (b)(14) of this section.

(27) Gains on disposal of assets. See subsection (b)(7)(F) of this section.

(28) Gifts. See subsection (b)(15) of this section.

(29) Goodwill. See subsections (b)(7) and (17)(C)(ii) of this section.

(30) Grants, gifts and income from endowments. See subsection (b)(15) of this section.

(31) In-kind donations. See subsection (b)(16) of this section.

(32) Insurance expense. See subsection (b)(10) of this section.

(33) Interest expense. See subsection (b)(8) of this section.

(34) Legal fees. See subsection (b)(2)(C)(ii) of this section.

(35) Life insurance. See subsection (b)(10)(G) of this section.

(36) Litigation expenses and awards. See subsection (b)(17)(I) of this section.

(37) Lobbying costs. See subsection (b)(17)(J) of this section.

(38) Losses on disposal of assets. See subsection (b)(7)(F) of this section.

(39) Losses due to theft. See subsection (b)(17)(L) of this section.

(40) Management fees. See subsection (b)(3) of this section.

(41) Medicaid as payor of last resort. See subsection (b)(18) of this section.

(42) Medical supplies and medical costs. See subsection (b)(17)(F) of this section.

(43) Nonpaid workers. See subsection (b)(2)(D) of this section.

(44) Operating Revenue. See subsection (b)(15)(D) of this section.

(45) Organization costs. See subsection (b)(17)(B) of this section.

(46) Payroll taxes and insurance. See subsection (b)(1)(A)(ii) of this section.

(47) Penalties. See subsection (b)(17)(G) of this section.

(48) Planning and evaluation expenses. See subsection (b)(7)(E) of this section.

(49) Promotional activities. See subsection (b)(14) of this section.

(50) Public relations. See subsection (b)(13) of this section.

(51) Repairs and maintenance. See subsection (b)(6) of this section.

(52) Research and development costs. See subsection (b)(17)(E) of this section.

(53) Salaries and wages. See subsections (b)(1) and (2) of this section.

(54) Self-insurance. See subsection (b)(10)(B) of this section.

(55) Staff training costs. See subsection (b)(12)(A) of this section.

(56) Startup costs. See subsection (b)(17)(D) of this section.

(57) Tax expense and credits. See subsection (b)(9) of this section.

(58) Travel costs. See subsection (b)(12)(B) of this section.

(59) Utilities. See subsection (b)(5) of this section.

(60) Volunteers. See subsection (b)(2)(D) of this section.

(61) Voucher-paid expenses. See subsection (b)(17) of this section.

(62) Workers' compensation insurance. See subsection (b)(10) of this section.

(b) Allowable and unallowable costs.

(1) Compensation of employees. Compensation includes both cash and non-cash forms of compensation subject to federal payroll tax regulations. Compensation includes wages and salaries (including bonuses); payroll taxes and insurance; and fringe 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 Worker's Compensation Insurance.

(A) Allowable compensation of employees is compensation paid to employees in arm's-length transactions as nonowners and non-related parties and is subject to the reasonable and necessary costs which must be incurred by providers in the provision of contracted client services. Guidelines for compensation of owners and related parties are specified in paragraph (2) of this subsection.

(i) A bonus is a type of compensation granted to employees as a wage enhancement. Bonuses paid to employees in arm's-length transactions are allowable costs, subject to the reasonable and necessary costs which must be incurred by providers in the provision of contracted client services. In determining the employee classification type, part-time employees may be considered a different classification type than full-time employees. To be allowable, bonuses to owners and/or related parties:

(I) must not represent any form of profit sharing and must not be determined on the level of profit earned by the contracted provider;

(II) effective with the 1996 cost report, must be clearly defined in a written agreement or employment policy;

(III) must not be made only to related parties, in which case the bonuses are unallowable costs;

(IV) must be based upon the same criteria for all members of the same employee classification type;

(V) must be made available to all employees of the same classification type, unless the employee classification type predominantly consists of related parties, in which case the bonuses are unallowable costs; and

(VI) must not discriminate in favor of certain employees, such as employees who are officers, stockholders, or the highest paid individual(s) of the organization.

(ii) Payroll taxes and insurance are described in paragraph (9) of this subsection, concerning tax expense and credits, and paragraph (10) of this subsection.

(iii) Fringe benefits are amounts paid to or on behalf of an employee, in addition to direct salary or wages, and from which the employee, his dependent, or his beneficiary derives a personal benefit before or after the employee's retirement or death.

(I) Fringe benefits paid to employees in arm's length transactions as nonowners and non-related parties are allowable costs, subject to the reasonable and necessary costs which must be incurred by providers in the provision of contracted client care. To be allowable, fringe benefits paid to owners and/or related parties must not discriminate in favor of certain employees, such as employees who are officers, stockholders, or the highest paid individual(s) of the organization.

(II) Allowable fringe benefits are reported on cost reports either as salaries and/or wages, as employee benefits, or as costs applicable to specific cost areas. Any fringe benefit subject to payroll taxes is reported as salary and wages. Allowable fringe benefits which are routinely reported as salaries and wages include paid vacations, paid holidays, sick leave, voting leave, court or jury duty leave, and/or all-inclusive paid days, as specified in subclause (III)(-c-) of this clause. Allowable fringe benefits which are routinely reported

as employee benefits include employer contributions to certain deferred compensation plans, as specified in subclause (III)(-a-) of this clause, employer contributions to an employee retirement fund or certain pension plans, as specified in subclause (III)(-b-) of this clause, and costs of certain employer-paid health, life, and disability insurance premiums, as specified in subclause (III)(-f-) of this clause. The contracted provider's unrecovered cost of meals and room and board furnished to direct care employees are fringe benefits which are reported as costs applicable to specific cost areas, as specified in subclause (III)(-e-) of this clause, unless they are subject to payroll taxes, whereas they are reported as salaries and wages.

(III) Fringe benefits include the following:

(-a-) Employer contributions to certain deferred compensation plans. Deferred compensation is remuneration currently earned by an employee but which is not received until a subsequent period, usually after retirement. For the cost to be allowable, the deferred compensation plan must be formal, established, and maintained by the contracted provider and communicated to all eligible employees. A formal plan is one that is provided for in a written agreement executed between the contracted provider and the participating employees. The plan must:

(-1-) prescribe the method for calculating all contributions to the fund;

(-2-) be funded with contributions made systematically to a funding agency outside the contracted provider's ownership or control, such as a trustee, an insurance company, or a custodial bank account;

(-3-) provide for the protection of the plan's assets;

(-4-) designate the requirements for vested benefits;

(-5-) provide the basis for the computation of the amounts of benefits to be paid;

(-6-) be expected to continue despite normal fluctuations in the contracted provider's economic experience; and

(-7-) use all fund contributions and earnings for the sole benefit of the participating employees. Contributions made during the cost-reporting period to a deferred compensation plan meeting the requirements specified in subitems (-1-)-(-7-) of this item which represent legal obligations of the contracted provider and which are clearly enumerated as to dollar amount are allowable costs and should be reported on cost reports as employee benefits. Reasonable trustee or custodial fees paid by the contracted provider will be allowed as an administrative cost. However, such fees will not be allowable where the deferred compensation plan provides that they will be paid out of the corpus or earnings of the fund.

(-b-) Employer contributions to an employee retirement fund or certain pension plans. A pension plan is a type of deferred compensation plan which is established and maintained by the employer to provide systematic payment of definitely determinable benefits to its employees over a period of years, or for life, after retirement. Such a plan may include disability, withdrawal, option for lump-sum payment, or insurance or survivorship benefits incidental and directly related to the pension benefits. A pension plan must meet all the requirements of a deferred compensation plan. All employees' pension fund rights must be nonforfeitable after such time as they vest under the plan. Pension fund rights cannot be contingent on continuance of employment or other factors. Only the amount the contracted provider or employer contributed to the pension fund during the reporting period is allowable and should be reported as an employee benefit. To be allowable, contributions representing the employee's share cannot revert to the contracted provider. However employer-paid contributions can revert to the contracted provider in the event an employee does not vest.

(-c-) Paid vacations, paid holidays, sick leave, voting leave, court or jury duty leave, and/or all-inclusive paid days, all are reported as employee salaries and/or wages rather than as employee benefits, as follows:

(-1-) A vacation benefit is a right granted by an employer to an employee to be absent from his job for a stipulated period of time without loss of pay or to be paid an additional salary in lieu of taking a vacation. The contracted provider's vacation policy must be consistent among all employees of a specific category. Vacation expense subject to payroll taxes must be reported as salaries and wages. Accrued vacation expense not yet subject to payroll taxes 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.

(-2-) The cost of sick leave taken, or payment in lieu of sick leave taken, is not to exceed the salary or wage the employee would have earned had they reported for work. Sick leave costs subject to payroll taxes must be reported as salaries and wages. Accrued sick leave costs not yet subject to payroll taxes 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.

(-3-) A formal plan for all-inclusive paid days off (PDO) is one under which all employees earn accrued vested leave, or payment in lieu of leave taken, for an unallocated combination of occasions such as illness, medical appointments, holidays, vacations, family leave, and care of a sick child, based on actual hours worked. The cost of PDO subject to payroll taxes must be reported as salaries and wages. Accrued costs of PDO not yet subject to payroll taxes 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.

(-d-) Provider-paid instructional courses benefiting the employee's interest. Costs related to provider-paid instructional courses for the benefit of the employee only are unallowable costs. Refer to (12)(A) of this subsection, concerning staff training costs.

(-e-) Contracted provider's unrecovered cost of meals and room and board furnished on-site to direct care employees. Any reasonable unrecovered cost of meals and/or room and board furnished on-site by a contracted provider to its direct care employees, which are equivalent to the meals and/or room and board provided to clients, are allowable costs since they are related to client care in that such reasonable costs are appropriate and helpful in developing and maintaining the contracted provider's operations to deliver contracted services. Such allowable costs should be reported in the cost area where the costs were incurred, such as meal costs being reported in the cost area associated with food and meal preparation and room and/or board costs being reported in the cost area associated with building costs.

(-f-) Costs of health, disability and life insurance premiums paid or incurred by the contracted provider if the benefits of the policy are

payable to the employee or beneficiary. Report allowable health, disability, and life insurance premium costs as employee benefits. Refer to (10) of this subsection, concerning insurance expense.

(B) Unallowable compensation of employees includes forms of compensation that are not clearly enumerated as to dollar amount or which represent profit or surplus revenue distributions are unallowable costs. Accrued expenses that are not legal obligations of the contracted provider are unallowable costs, including any form of profit sharing and the accrued liabilities of unfunded deferred compensation plans

(2) 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 fringe 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 Worker's Compensation Insurance). Allowable compensation must be reported as salaries and not as management fees.

(A) Allowable compensation of owners and related parties.

(i) 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 for the purposes of this . Allowable compensation for a related party, as defined in §409.9(i) of this title (relating to General Principles of Allowable and Unallowable Costs), a sole proprietor-employee, a partner-employee, or a corporate stockholder-employee is governed by the principles that the services rendered are necessary functions and that the remuneration is the reasonable value of the services rendered.

(I) A function is deemed necessary when, if the owner or related party had not performed said function, the contracted provider would have had to employ another person to perform that function. To be necessary, a function must pertain to direct or indirect activities in the provision or supervision of contracted client services. The fact that an owner may have potential supervisory and managerial authority and responsibility is not as important as the manner in which this authority and responsibility is actually exercised. As an example, the right of the owner-administrator to overrule decisions does not solely constitute a basis for recognition of compensation comparable to nonowner-administrators.

(II) The test of reasonableness requires that the compensation of owners or related parties be such an amount as would ordinarily be paid for comparable services performed by nonowners or unrelated parties Reasonable compensation is limited to the fair market value of services rendered by the owner or related party in connection with contracted client care. Education and experience of the owner are pertinent only as they relate to the job being performed and the services being rendered. For example, where an owner-administrator is also a physician or a nurse or a lawyer, but the services evaluated are administrative in nature rather than the actual practice of medicine or nursing or law, the allowable compensation is based on the compensation nonphysician or nonnurse or nonlawyer administrators receive rather than on the rate physicians or nurses or lawyers receive for their professional services.

(ii) The compensation must be for services performed by the related party, owner, partner, or stockholder that do not duplicate services performed by another employee of the contracted provider.

(iii) Compensation for "full-time" service requires that at least 40 hours per week be devoted to the duties of the position for which compensation is requested. For owners devoting less than 40 hours per week to the position, allowable compensation is limited to the proportion of 40 hours actually devoted to the contract services. Documentation regarding owners and related parties must be kept in accordance with §409.12(b)(2)(B)(xi) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(iv) Compensation must be in accordance with (1)(A) of this subsection concerning compensation of employees, must be made in regular periodic payments, must be subject to payroll or self-employment taxes, and must be verifiable by adequate documentation maintained by the contracted provider.

(B) Unallowable compensation of owners and related parties

(i) Forms of compensation that are not clearly enumerated as to dollar amount or which represent profit or surplus revenue distributions are unallowable costs.

(ii) Compensation in the form of salaries, benefits, or any form of perquisite provided to owners, partners, officers, directors, stockholders, employees, or others who do not provide services directly to clients or who do not provide services required in the normal conduct of operations to provide contracted client services, is an unallowable cost. Services which would be required in the normal conduct of operations to provide contracted client services would include expenses such as administration of the program or supervision of direct care staff.

(C) Compensation for outside consultants and fees for services provided by outside vendors. Allowable compensation for outside consultants and contracted services must meet the criteria in §409.9 of this title (relating to General Principles of Allowable and Unallowable Costs) Specific criteria for certain types of compensation of outside consultants and contracted services are as follows:

(i) Accounting and audit fees.

(I) Allowable accounting and audit fees. Fees for preparation of business tax reports and returns, financial statements, and cost reports are allowable costs. Audit fees associated with the performance of a financial audit are allowable costs.

(II) Unallowable accounting and audit fees. Expenses related to the preparation of personal tax returns are unallowable costs as are certain taxes. Refer to paragraph (9) of this subsection, concerning tax expense and credits. Audit fees associated with the performance of a single audit are unallowable costs. The costs attributable to a financial audit that was conducted along with a single audit is allowable if the cost of the financial audit can be identified separately from the cost attributable to the single audit. Accounting fees and related costs associated with litigation between a provider and a governmental entity are unallowable. Accounting costs associated with any other unallowable costs are also unallowable. Fees related to the preparation of annual reports, reports to stockholders or other interested parties, or for investment management are unallowable costs.

(ii) Legal fees. Legal retainers are not allowable in and of themselves, but rather must be documented as specified in §409.12(b)(2)(B) (viii) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures). Legal costs associated with litigation between a provider and a governmental entity are unallowable. Legal costs associated with any other unallowable costs are also unallowable.

(D) Value of services of nonpaid workers. Since the contracted provider incurs no actual costs for Nonpaid and/or volunteer workers, the value of the Nonpaid work is not an element of cost; and the value of such Nonpaid work is an unallowable cost.

(E) Boards of directors. Boards of directors fees are unallowable costs. Errors and omissions (liability) insurance for boards of directors are allowable costs. Travel and per diem expenses related to board members will be allowable up to the maximum allowable travel guidelines as stated in (12)(B) of this subsection.

(3) Management fees.

(A) Allowable management fees. Reasonable management fees paid to unrelated parties are allowable costs. Allowable management fees paid to related parties are the actual costs to the related party for the materials, supplies, and services provided directly to the individual contracted provider. Any related party compensation or owner compensation included in allowable management fees paid to related parties must follow the guidelines specified in §409.9(i) of this title (relating to General Principles of Allowable and Unallowable Costs) and in subsection (b)(2) of this section, concerning compensation of owners and related parties. Expenses for management provided by the contracted provider's central office must be reported as central office costs on the cost report. Cash management fees related to minimizing interest costs and banking expenses in the management of operating revenue necessary for contracted services are allowable costs.

(B) Unallowable management fees. Fees for management of personal investments or investments not necessary for the provision of contracted services are unallowable costs.

(4) Central office costs. A chain organization consists of a group of two or more contracted entities which are owned, leased or controlled through any other arrangement by one organization. A chain may also include business organizations which are engaged in other activities which are not contracted program entities. Central offices of a chain organization vary in the services furnished to the components in the chain. The relationship of the central office to an entity providing contracted services is that of a related party organization to a contracted provider. Central offices usually furnish central management and administrative services such as central accounting, purchasing, personnel services, management direction and control, and other necessary services. To the extent the central office furnishes services related directly or indirectly to contracted client care, the reasonable costs of such services are allowable. Allowable central office costs include costs directly related to those services necessary for the provision of client care for contracted services in Texas and an appropriate share of allowable indirect costs. Where functions of the central office have no direct or indirect bearing on delivering contracted client care, the cost for those functions are not allowable costs. Costs which are unallowable to the contracted provider are also unallowable as central office costs. Where a contracted provider is furnished services, facilities, or supplies from its central office, the costs allowed are subject to the guidelines of related party transactions in §409. 9(i) of this title (relating to General Principles of Allowable and Unallowable Costs). Owner-employees and related parties receiving compensation for services provided through the central office are allowable to the extent provided in paragraph (2)(A) and (B) of this subsection, concerning compensation of owners and related parties.

(5) Utilities. To be allowable, the utilities must be used directly or indirectly in the provision of contracted services.

(6) Repairs and maintenance. For cost-reporting purposes, repairs and maintenance are categorized as ordinary or extraordinary (major) repairs and should be handled as follows.

(A) Ordinary repairs and maintenance are defined as outlays for parts, labor, and related supplies which are necessary to keep the asset in operating condition, but neither add materially to the use value of the asset nor prolong its life appreciably. Ordinary repairs are recurring and usually involve relatively small expenditures. Ordinary repairs include, but are not limited to, painting, wall papering, copy machine repair, repairing an electrical circuit, or replacing spark plugs. Because maintenance costs and ordinary repairs are similar, they are usually combined for accounting purposes. Ordinary repairs may be expensed.

(B) Extraordinary repairs (major repairs) involve relatively large expenditures, are not normally recurring in nature, and usually increase the use value (efficiency and use utility) or the service life of the asset beyond what it was before the repair. Extraordinary repairs costing $1,000 or more, with a useful life in excess of one year, should be capitalized and depreciated. The cost of the extraordinary repair should be added to the cost of the asset and depreciated over the remaining useful life of the original asset. If the life of the asset has been extended due to the repair, the useful life should be adjusted accordingly. Extraordinary repairs include, but are not limited to, major vehicle overhauls, major improvements in a building's electrical system, carpeting an entire building, replacement of a roof, or strengthening the foundation of a building.

(7) Depreciation and amortization expense. For purchases made after the beginning of the contracted provider's fiscal year 1996, an asset valued at $1,000 or more and with an estimated useful life of more than one year at the time of purchase must be depreciated or amortized, using the straight line method. In determining whether to expense or depreciate a purchased item, a contracted provider may expense any single item costing less than $1,000 or having a useful life of one year or less. Depreciation and amortization expenses for unallowable assets and costs are also unallowable, including amounts in excess of those resulting from the straight line method, capitalized lease expenses in excess of actual lease payments, and goodwill or any excess above the actual value of physical assets at the time of purchase. The minimum useful lives to be assigned to common classes of depreciable property are as follows:

(A) Buildings. A building's life must be reported as a minimum of 30 years, with a minimum salvage value of 10%. All buildings, excluding the value of the land, are uniformly depreciated on a 30-year life basis, regardless of the actual date of construction or original purchase. Exceptions to this policy are permissible when contracted providers choose a useful-life basis in excess of 30 years. An example of depreciation on a 30-year life basis is: For example: building historical cost (excluding land) $110,000 less 10% salvage value-11,000 depreciable basis $99,000 divided by 30 years = $ 3,300 depreciation expense per year.

(B) Building equipment; buildings and grounds improvements and repairs; durable medical equipment, furniture, and appliances; and power equipment and tools used for buildings and grounds maintenance. Use minimum schedules consistent with "Estimated Useful Lives of Depreciable Hospital Assets," published by the American Hospital Association. Copies of this publication may be obtained by contacting American Hospital Publishing, Inc., 737 North Michigan Avenue, Chicago, IL 60611. Leasehold improvements whose estimated useful lives according to the guidelines for depreciable hospital assets are longer than the term of the lease must be depreciated and/or amortized over the re-

maining life of the lease or the life of the leasehold improvement, whichever is longer. Building improvements which are not structural in nature and do not extend the depreciable life of the building, but whose estimated useful lives according to the guidelines for depreciable hospital assets are longer than the remaining depreciable life of the building, must be depreciated over the normal useful life of the building improvements, or the remaining life of the building, whichever is longer. Once the estimated useful life of the leasehold improvement has been established using the guidelines above, subsequent extensions of the lease period do not change the useful life of the leasehold improvement. Any exceptions to this policy shall be stated in §409.19 of this title (relating to Program-Specific Allowable and Unallowable Costs).

(C) Transportation equipment used for the transport of clients, staff, or materials and supplies utilized by the contracted provider. Cost reporting must reflect a minimum of three years for automobiles (including minivans); five years for light trucks and vans; and seven years for buses and airplanes. Depreciation expenses for transportation equipment not generally suited or not commonly used to transport clients, staff, or provider supplies are unallowable costs. This includes motor homes and recreational vehicles; sports automobiles; motorcycles; heavy trucks, tractors and equipment used in farming, ranching, and construction; and transportation equipment used for other activities unrelated to the provision of contracted client care, unless §409. 19 of this title (relating to Program-Specific Allowable and Unallowable Costs) provides otherwise. Refer to §409.12(b)(2)(B)(iii) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures) for requirements for the maintenance of mileage logs and other documentation required to substantiate transportation equipment costs.

(i) Luxury automobiles are defined for cost-reporting purposes as passenger vehicles, excluding buses, with an historical cost at time of purchase or a market value at execution of the lease exceeding $30,000 when purchased or leased before January 1, 1996. For vehicles leased or purchased on or after January 1, 1996, luxury vehicles are defined as a base value of $30,000 with 2 0% being added (using the compound method) to the base value each January 1 beginning on January 1, 1997. Any amount above the definition of a luxury vehicle stated above is an unallowable cost. When a passenger vehicle's cost exceeds the amount determined by the definition of a luxury vehicle stated above, the historical cost is reduced to the amount determined by the definition of a luxury vehicle. When a passenger vehicle's market value at the execution of the lease exceeds the amount determined by the definition of a luxury vehicle stated above, the allowable lease payment is limited to the lease amount for a vehicle with the base value as determined above, with substantiating documentation as specified in §409.12(b)(2)(B)(iv) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures). Luxury vehicles must be depreciated according to depreciation guidelines in this paragraph. Expenses for passenger luxury vehicles will be allowable if the contracted provider maintains adequate mileage logs substantiating the use of the luxury vehicles to transport clients, contracted provider staff or provider supplies. Refer to §409.12(b)(2)(B)(iii) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures) for requirements for the maintenance of mileage logs. The base value does not include specialized equipment, such as wheelchair lifts, added to assist clients.

(ii) The estimated life of a previously owned (used) vehicle is the longer of the number of years remaining in the vehicle's depreciable life or three years. For example, if a 1994 van were purchased in 1995, it would have four years remaining in its five-year depreciable life and that would become the depreciable life for the used vehicle. If a 1994 minivan were purchased in 1995, it would have two years remaining in its three-year depreciable life and the depreciable life for the used vehicle would then be three years.

(iii) Specialized equipment added to a vehicle to assist a client should be depreciated separately from the vehicle. Wheelchair lifts have an estimated useful life of four years

(D) Depreciation for the first reporting period. Depreciation for the first reporting period is based on the length of time from the date of acquisition to the end of the reporting period. Depreciation on disposal is based on the length of time from the beginning of the reporting period in which the asset was disposed to the date of disposal.

(E) Planning and evaluation expenses. Planning and evaluation expenses for the purchase of depreciable assets are allowable costs only where purchases are actually made and the assets are put into service in the provision of care by the provider for contracted services.

(F) Gains and losses. Gains and losses realized from the trade-in or exchange of depreciable assets are included in the determination of allowable cost. When an asset is acquired by trading-in an asset that was being depreciated, the historical cost of the new asset is the sum of the undepreciated cost of the asset traded-in plus any cash or other assets transferred or to be transferred to acquire the new asset. Losses resulting from the involuntary conversion of depreciable assets, such as condemnation, fire, theft, or other casualty, are includable as allowable costs in the year of involuntary conversion, provided the total aggregate allowable losses incurred in any cost-reporting period do not exceed $5,000 and provided the assets are replaced. If the total aggregate allowable losses in any cost-reporting period exceed $5,000, the total amount of the losses over $5,000 is recognized as a deferred charge and treated as follows:

(i) If a depreciable asset is destroyed by an involuntary conversion beyond repair, then the amount of the loss over $5,000 must be capitalized as a deferred charge over the estimated useful life of the asset which replaces it. The allowable loss for a total casualty is the undepreciated cost of the asset, less insurance proceeds, gifts, and grants from any source as a result of the involuntary conversion. If the unrepairable asset is disposed of by scrapping, income received from salvage is treated as a reduction in the amount of the allowable loss. Conversely, where additional expense is incurred in the scrapping operation, such cost would be added to the allowable loss of the destroyed asset.

(ii) If a depreciable asset is partially destroyed or damaged as a result of an involuntary conversion, a reduction in its cost basis is assumed to have taken place. Therefore, the cost basis of the asset must be reduced to reflect the amount of the casualty loss, regardless of whether the loss is covered by insurance.

(I) The amount of the casualty loss is the difference between the fair market value immediately before the casualty and the fair market value immediately after the casualty; however, for cost-reporting purposes, the allowable loss is limited to the percent of loss in fair market value applied to the net book value of the asset at the time the casualty occurred. This method of calculating the allowable loss recognizes the actual reduction in the cost value of the asset rather than the reduction in replacement value.

(II) Any loss over $5,000 must be capitalized as a deferred charge and amortized over the useful life of the restored asset.

(III) The fair market value generally can be ascertained by competent appraisal. If no appraisal is made, the cost of repairs to the damaged property is acceptable as evidence of the loss of value if the repairs restore the property to its condition immediately before the casualty and, as a result of the repairs, the value of the property has not been increased. The amount of the allowable loss is then deducted from the cost basis of the asset before the casualty, to arrive at the adjusted cost basis of the asset. Any insurance proceeds received or recoverable must be deducted from the amount of the casualty loss to determine the gain or the loss.

(IV) Actual costs incurred in the restoration of an asset are added to the adjusted cost basis of the asset to arrive at the revised cost of the restored asset and capitalized over the remaining useful life of the restored asset.

(V) When the repairs materially improve or add to the value or utility of the property or appreciably prolong its useful life, the repairs must be depreciated over the estimated life of the repairs.

(VI) When the contracted provider maintains a self-insurance reserve fund the amount of the casualty loss recognized as an allowable cost is limited to the lesser of the decrease in fair market value, as adjusted, of the damaged or destroyed asset or the amount of cash, and/or investments, comprising the accumulated balance of the self-insurance reserve account.

(VII) When an asset is sold before the end of its useful life and a gain is realized (the sales price is greater than the remaining allowable depreciation), no additional depreciation or expense is allowed.

(8) Interest expense. Reasonable and necessary interest on current and capital indebtedness is an allowable cost. In the case of allowable interest incurred on a loan, in order to be determined necessary, the loan must have been made to satisfy a financial need for a purpose reasonably related to contracted client care.

(A) For cost-reporting purposes, allowable interest expenses are limited to that net portion of interest accrued which has not been reduced or offset by interest income. To be allowable, the following requirements must be met.

(i) The loan must be supported by evidence in writing of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required and systematically made. Refer to §409.12(b)(2)(B) (ii) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures);

(ii) The loan must be made in the name of the contracted provider entity as maker or comaker of the note; and

(iii) The proceeds of the note or loan must be used for allowable costs.

(B) Interest expense on a demand note is allowable if the loan is the result of an arm's-length transaction.

(C) Where the lender is a related party, allowable interest is limited to the prevailing national average prime interest rate in effect at the time at which the loan contract was finalized, as reported by the United States Department of Commerce, Bureau of Economic Analysis in the Survey of Current Business.

(D) Interest costs incurred during the period of construction or enlarging of a building must be capitalized as part of the cost of the building.

(E) Reasonable finance charges and service charges, together with interest on indebtedness, are allowable costs.

(F) Other fees associated with obtaining an allowable loan, such as broker's fees to solicit financing, lender's fees, attorney's fees, and due diligence fees, are allowable costs.

(G) Interest expenses on funds borrowed for purposes of investing in operations other than contracted services, on loans pertaining to unallowable items, and on borrowed funds creating excess working capital are unallowable costs.

(9) Tax expense and credits.

(A) Generally, taxes assessed against the contracted provider, in accordance with the levying enactments of Texas and lower levels of government and for which the contracted provider is liable for payment, are allowable costs. Tax expense based on fines and penalties are unallowable costs.

(B) Employment-related taxes such as Federal Insurance Contribution Act, Workers' Compensation and Unemployment Compensation, are allowable costs. Refer to paragraph (1)(A) and (C) of this subsection.

(C) Franchise taxes are allowable costs. A franchise tax is a periodic assessment, as defined by the Texas Comptroller of Public Accounts and paid to the Texas State Treasurer, levied on the operation of a business in the State of Texas. Franchise taxes do not refer to franchise fees, which are the costs associated with a company's granting the right to sell its products or services in a specified territory.

(D) Unallowable taxes include:

(i) Federal income taxes and excess profit or surplus revenue based taxes, including any interest or penalties paid thereon. However, fees for preparation of business tax reports and business returns required by law are allowable.

(ii) State or local income and excess profit or surplus revenue based taxes. However, fees for preparation of business tax reports and/or business returns are allowable.

(iii) Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bonds, property transfers, issuance or transfer of stocks. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are, however, unallowable as tax expense.

(iv) Taxes from which exemptions are available to the contracted provider.

(v) Special assessments on land which represent capital improvements should be capitalized and depreciated over their estimated useful lives and are not allowable as tax expenses.

(vi) Taxes, such as sales taxes, levied against the client and collected and remitted by the contracted provider.

(vii) Self-employment taxes.

(10) Insurance expense. This section covers the following types of insurance: property damage and destruction; fire and casualty; malpractice and comprehensive general liability; errors and omissions insurance covering boards of directors; theft insurance (fidelity bonds and burglary insurance); workers' compensation; transportation equipment insurance; life insurance for owners, officers, and key employees; health; disability; and unemployment compensation.

(A) Purchased and commercial insurance. The reasonable costs of insurance purchased from a commercial carrier or a nonprofit service corporation are allowable if resulting from an arm's-length transaction. The commercial carrier or nonprofit service corporation must meet the standards as set by the Texas Department of Insurance. Costs of insurance purchased from a limited purpose insurer are allowable if they are not in excess of the cost of available comparable commercial insurance premiums and meet the reasonable cost provisions. If comparable insurance premiums are not available, the limited purpose insurer or captive insurance company must obtain an evaluation of the adequacy and reasonableness of its insurance premium by an independent actuary, commercial insurance company, or broker.

(B) Self-Insurance. Self-insurance is a means whereby a contracted provider undertakes the risk to protect itself against anticipated liabilities by providing funds in an amount equivalent to liquidate those liabilities. Self-insurance can also be described as being uninsured. To qualify as an allowable self-insurance plan a contracted provider must enter into an agreement with an unrelated party that does not provide for the shifting of risk to the unrelated party designed to provide only administrative services to liquidate those liabilities and manage risks. Self-insurance costs for contracted providers who have received certificates of authority to self-insure from the Texas Workers' Compensation Commission are allowable costs. Self-insurance costs in excess of costs for similar, comparable coverage by purchased and/or commercial insurance premiums are unallowable costs. Documentation substantiating the cost of comparable coverage by purchased and/or commercial insurance premiums must be obtained and maintained as specified in §409.12(b)(2)(B)(ix) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(i) Costs related to self-insurance are allowable on a claims-paid basis. Contributions to the self-insurance fund or reserve which do not represent payments based on current liabilities are not considered actual incurred expenses and are not allowable costs. For cost-reporting purposes, self-insurance costs are reported on a cash basis. For cost-reporting purposes, compensation paid to employees who have been injured on the job is allowable and should be reported as compensation according to the type of compensation expense incurred in accordance with §409.10(b)(1) and (2) of this title (relating to Specifications for Allowable and Unallowable Costs).

(ii) For cost-reporting purposes, allowable employee-related paid claims, such as health insurance and workers' compensation costs, may either be directly charged to the business component in which the employee worked or may be allocated across all business components as an administrative expense. The method chosen to report these costs must remain consistent each year. Changes in the method for reporting those costs must be approved in accordance with §409.9(j) of this title (relating to General Principles of Allowable and Unallowable Costs.)

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

(D) Reporting of insurance costs. All allowable insurance premium costs should be reported on cost reports, with amounts accrued for premiums, modifiers, and surcharges during the cost-reporting period being adjusted by any refunds and discounts actually received or settlements paid during the same cost-reporting period.

(E) Losses in excess of coverage. When a contracted provider is not fully insured by a purchased commercial insurance policy, i.e., the provider's coverage includes coinsurance provisions and/or deductibles, the amount of allowable insurance costs reported for each cost-reporting period is subject to a cost ceiling.

(i) The cost ceiling for employee-related insurance, such as health insurance, or workers' compensation coverage, is either the amount that would have been incurred had the provider purchased full coverage for its entire business entity through a commercial insurance policy or an amount equal to 10% of the payroll for employees eligible for such coverage.

(ii) The cost ceiling for non-employee-related insurance, such as malpractice insurance, comprehensive general liability insurance, or property insurance, is the amount that would have been incurred had the provider purchased full coverage for its entire business entity through a commercial insurance policy.

(iii) If, during a cost-reporting period, a provider incurs allowable paid claims in excess of the applicable cost ceiling, the provider reports on its current cost report allowable insurance costs up to the amount of the applicable cost ceiling, with the allowable costs in excess of the applicable cost ceiling being carried forward to future cost-reporting periods When, during a future cost-reporting period, a provider incurs allowable insurance costs in an amount less than the applicable cost ceiling, the provider reports on its cost report the allowable insurance costs (paid claims) incurred during that cost-reporting period plus any allowable carry forward amount up to the amount of the applicable cost ceiling, with any excess carry forward being carried forward to future cost reporting periods.

(iv) Documentation requirements are stated in §409.12(b)(2)(B)(ix) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(F) Absence of coverage. Where a contracted provider, other than a governmental provider, has no insurance protection, the reporting of the provider's paid claims must follow the guidelines stated in (10)(E) of this subsection. For governmental providers, allowable paid claims for cost-reporting purposes include all claims paid during the cost-reporting period only if the provider demonstrates that it has a claims management and risk management program.

(G) Life insurance costs.

(i) Unallowable life insurance costs. In general, premiums related to insurance on the lives of owners, officers, and key employees where the contracted provider is a direct or indirect beneficiary are unallowable costs.

(ii) Life insurance costs are allowable if:

(I) a contracted provider is required by a lending institution or other lender to purchase such insurance to guarantee the outstanding loan balance;

(II) the lending institution or other lender must be designated as the beneficiary of the insurance policy; and

(III) upon the death of the insured, the proceeds are restricted to paying off the balance of the loan.

(iii) Allowable insurance premiums are limited to premiums equivalent to that of a decreasing term life insurance policy needed to pay off the outstanding loan balance or that portion of the premium which can be equated to the premium for a similar face amount of a decreasing term life policy. In addition, the loan must be reasonable and necessary and must meet the criteria for allowable loans and interest expense as stated in §409.10(b)(8) of this title (relating to Specification of Allowable and Unallowable Costs).

(iv) Provider-paid premiums related to insurance on the lives of owners-employees, officers, and key employees where the individual's relatives or estate are the beneficiary are considered to be employee benefits to the individual and are allowable costs to the extent such employee benefits are allowable. Provider-paid premiums related to insurance on the lives of owners-employees, officers, and key employees where required by a financial institution and the financial institution is the beneficiary is allowable.

(H) Insurance costs pertaining to unallowable costs. Insurance costs pertaining to items of unallowable costs are themselves unallowable costs.

(I) Board of directors' insurance. Errors and omissions insurance (liability) on members of boards of directors is an allowable cost.

(11) Dues or contributions to organizations.

(A) Allowable dues and contributions to organizations. Costs of membership in professional associations directly and primarily concerned with the provision of services for which the provider is contracted are allowable. Allowable costs of memberships in such organizations include initiation fees, dues, and subscriptions to related professional periodicals. Allowable costs related to meetings and conferences whose primary purpose is to disseminate information for the advancement of contracted client care or the efficient operation of the contracted program include reasonable costs for meals and transportation in accordance with (12)(B) of this subsection and reasonable registration fees and other costs incidental to those functions. Dues or licensing fees related to maintaining the professional accreditation or license of an employee are allowable to the extent that the professional accreditation or license is directly related to and necessary for the performance of that employee's functions.

(B) Unallowable dues and contributions to organizations. Dues to non-professional organizations are unallowable. Assessments whose purpose is to fund lawsuits or any legal action against the state or federal government are unallowable. Portions of dues based on revenue or for the purposes of lobbying, or campaign contributions are unallowable costs. Costs of membership in civic organizations whose primary purpose is the promotion and implementation of civic objectives are unallowable. Dues or contributions made to any type of political, social, fraternal, or charitable organization are unallowable. Chamber of Commerce dues are unallowable. Franchise fees are not considered dues or contributions to organizations.

(C) Dues to purchasing organizations and buying clubs. Allowable dues to purchasing organizations or buying clubs are limited to the pro-rata amount representing purchases made for use in providing contracted services.

(12) Training and travel costs.

(A) Staff training costs.

(i) Staff training costs refer to costs associated with educational activities for provider staff. To qualify as an allowable staff training cost, the training must:

(I) have a direct relationship with the employee's job responsibilities, thereby increasing the quality of contracted client care or the efficient operation of the contracted provider. Management training, if it is designed to enhance quality or improve administration and is relevant to the contracted service, is an allowable cost. The following apply to staff training costs.

(-a-) Non-related party staff. Costs of tuition, books, and related fees for courses required to complete the designated degree or certification are allowable. The degree or certification must be necessary to the provision of contracted client services of the contracted provider. An example would be any course required to be taken by a licensed vocational nurse (LVN) working toward a degree as a registered nurse (RN) where RN services are necessary to deliver services as required under the contract.

(-b-) Related party staff. Allowable costs are restricted to specific courses which have a direct relationship with the employee's job responsibilities. Examples of allowable staff training costs include tuition, books, and related fees for an accounting course for a bookkeeper and a management course for a supervisor. However, a history course for a bookkeeper, even though it may be a requirement for a college degree in accounting or business, is unallowable.

(II) be located within the state of Texas unless the purpose of the training is for staff training in contracted client care-related services or quality assurance which is not available in the State of Texas. All costs for training outside the continental United States are unallowable costs. For further guidelines regarding adequate documentation, refer to §409.12(b)(2)(B)(vi) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(ii) Staff training may be conducted within the provider setting or offsite. It may be operated by the contracted provider, provided by an accredited academic or technical institution, or conducted by a recognized professional organization for the particular training activity. Workshops on particular contracted client services, health applications, on-the-job safety, data processing, accounting, programmatic or cost related training, supervisory techniques, and other administrative activities are examples of allowable types of training. Costs of orientation, on-the-job training, and inservice are recognized as normal operating costs and are allowable training costs.

(iii) For staff training conducted within the provider setting, allowable training costs include, but are not limited to, instructor and consultant fees, training supplies, and visual aids. For offsite training, allowable costs include costs such as allowable travel costs, registration fees, seminar supplies, and classroom costs. For additional guidelines regarding allowable travel costs, please refer to (12)(B) of this subsection.

(iv) Staff training costs must be reported as net costs, having been offset by any reimbursement from grants, tuitions, or donations received for staff educational purposes.

(v) Client prevocational, vocational, and educational costs. Refer to §409.19 of this title (relating to Program-Specific Allowable and Unallowable Costs) for guidelines on allowability.

(B) Travel costs.

(i) Maximum allowable travel costs for employees and members of the Board of Directors are as follows:

(I) 150% of the limits established by the Texas Legislature for non-exempt state employees, with respect to hotel costs and per diem rates.

(II) the maximum allowable mileage reimbursement amount set by the Texas Legislature for non-exempt state employees.

(ii) Out-of-state travel costs are unallowable, unless the purpose of the travel is for staff training in contracted client-care-related services or in quality assurance which is not available in the state of Texas or for the purpose of delivering direct contracted client services within 25 miles of the Texas border with adjoining states. All costs for travel outside the continental United States are unallowable costs, with the singular exception of travel required for the delivery of direct contracted client services within 25 miles of the Texas-Mexico border.

(iii) Expenses for private aircraft are allowable only if:

(I) all criteria in flight logs are maintained as specified in §409.12(b)(2)(B)(iii) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures); and

(II) the contracted provider furnishes documentation demonstrating that the expenses for travel via private aircraft are not greater than those for commercial alternatives or ground transportation at the time the travel took place. Documentation demonstrating the cost of ground transportation may include the staff costs for the employee's time during the trip, and for commercial alternatives, the staff costs for the employee's time during the trip and at the termination/station.

(13) Advertising and public relations.

(A) Allowable advertising and public relations.

(i) Costs of advertising to meet statutory or regulatory requirements, such as program standards, rules, or contract requirements, are allowable costs.

(ii) Informational listings of contracted providers in a telephone directory, including yellow page listings up to one-eighth of a page per telephone directory in the providers' service area, or in a directory of similar facilities in a given area are allowable if the listings are consistent with practices that are common and accepted in the industry.

(iii) Costs of advertising for the purpose of recruiting necessary personnel are allowable costs. Refer to the definition of necessary in §409.9(f)(2) of this title (relating to General Principles of Allowable and Unallowable Costs).

(iv) Costs of advertising for procurement of items related to contracted client care, and for sale or disposition of surplus or scrap material are treated as adjustments of the purchase or selling price.

(v) Costs of advertising incurred in connection with obtaining bids for construction or renovation of the contracted provider's facilities should be included in the capitalized cost of the asset. Refer to paragraph (7) of this subsection.

(B) Unallowable advertising and public relations.

(i) Costs of advertising of a general nature designed to invite physicians to utilize a contracted provider's facilities in their capacity as independent practitioners;

(ii) Costs of advertising incurred in connection with the issuance of a contracted provider's own stock, or the sale of stock held by the contracted provider in another corporation are considered as reductions in the proceeds from the sale;

(iii) Costs of advertising to the general public which seeks to increase client utilization of the contracted provider's facilities;

(iv) Public relations costs;

(v) Any business promotional advertising; and

(vi) Costs of the development of logos or other company identification.

(14) Promotional and fundraising activities. Promotional refers to any activity whose intent is to advertise or aid in the development of the business. Expenses relating to fundraising and promotional activities are unallowable, including salaries, benefits, and payroll taxes for staff performing these activities. If a staff member performs these activities along with allowable activities, a portion of that staff member's salary must be allocated to these unallowable activities and as such not be reported on the cost report. Other expenses associated with these activities are also unallowable, including advertising, publicity, travel, and meals.

(15) Grants, gifts, and income from endowments and operating revenue.

(A) Restricted grants, gifts, and income from endowments from private sources used to purchase allowable program costs should not be deducted and offset from allowable costs prior to reporting on the cost report.

(B) Grants and contracts from federal, state or local government, such as transportation grants, United States Department of Agriculture grants, education grants, Housing and Urban Development grants, and Community Service Block Grants, should be offset, prior to reporting on the cost report, against the particular cost or group of costs for which the grant was intended. If federal funds are paid for the care of a specified client, those federal funds should not be offset prior to reporting on the cost report unless otherwise specified in §409.19 of this title (relating to Program-Specific Allowable and Unallowable Costs).

(C) Unrestricted grants, gifts, and income from endowments from private sources used to purchase allowable program items should not be offset by the contracted provider prior to reporting on the cost report. All unrestricted funds which are properly allocable to the cost report should be reported on a contracted provider's cost report, as well as any allowable costs to which the unrestricted funds were applied.

(D) Nonroutine revenues such as income from operations not associated with providing contracted services, including, but not limited to beauty and barber shops, vending machines, gift shops, canteen stores, and meals sold to employees or guests should be offset or reduced by the related expenses prior to reporting the revenue on the cost report. Expenses related to providing these types of non-contracted operations are unallowable costs. If nonroutine operating expenses, including overhead costs incurred to generate nonroutine operating revenue, exceed nonroutine operating revenues, the net nonroutine operating expenses are unallowable costs. Routine operating revenue received as payments for the contracted services, such as income from private clients, private room and board, or other sources of routine contracted services are not to be offset. Refer to §409.9(k) of this title (relating to General Principles of Allowable and Unallowable Costs) for further guidelines on reporting net expenses.

(16) In-kind donations.

(A) Allowable in-kind donations.

(i) Depreciation of in-kind donations is limited to donated buildings and donated vehicles used in the direct provision of contracted client services, where title has been transferred to the provider entity by a third party in an arm's-length transaction. Depreciation must be reported in accordance with §409.9(b)(7) of this title (relating to Specifications for Allowable and Unallowable Costs).The historical cost basis used to depreciate vehicles

must be consistent with the retail price of the National Automobile Dealers Association (NADA) listings; or in the case of a new vehicle, the documented historical cost to the donor or NADA may be used. The historical cost basis used to depreciate donated buildings must be the lower of:

(I) the most recent tax appraisal of the building prior to donation, unless the donor was exempt from the tax appraisal, in which case an independent appraisal made by a third-party appraiser at the time of donation may be used in place of the tax appraisal (for donations made prior to the provider's 1996 fiscal year, a current appraisal from an independent third-party appraiser may be used to establish the historical cost); or

(II) the documented historical cost to the donor.

(ii) Expenses actually incurred to maintain a donated asset for use in providing contracted client care to TDMHMR clients are allowable.

(iii) If a provider receives a donation of the use of space owned by another organization and if the provider and donor organization are both part of a larger organizational entity (such as units of a state or county government), the space is not considered a related-party donation, but rather treated as allowable costs requiring allocation between the provider and the other organization. For example, if an HCS home health agency is given space to use in the community MHMR office building, costs associated with the use of the space (such as depreciation, janitorial services, maintenance, and repairs) must be allocated from the community MHMR to the HCS home health agency. Allocation of costs must be in compliance with §409.9(i) of this title (relating to General Principles of Allowable and Unallowable Costs).

(B) Unallowable in-kind donations. The value of unallowable in-kind donations may be collected for specific programs at the discretion of TDMHMR for statistical purposes only, on a schedule separately identified for such purpose. The value of in-kind donations to a contracted provider, such as produce, supplies, materials, services, equipment, or other items used by the contracted provider which the contracted provider did not purchase, is an unallowable cost. The value of in-kind donations of buildings or vehicles when the title is not transferred to the provider is an unallowable cost. The value of in-kind donations to a contracted provider which are not arm's-length transactions are unallowable costs. The contracted provider may not treat as an allowable cost the imputed value for unallowable in-kind donations.

(17) Miscellaneous costs.

(A) Employee relations expenses. Costs relating to employee relations are different from fringe benefits, as specified in paragraph (1)(A)(iii) of this subsection, in that employee relations expenses incurred are for employees as a group rather than as a fringe benefit for an individual employee. Examples of allowable employee relations costs, which are reported as administrative costs for cost-reporting purposes, include a staff party, an employee outing, or other such staff expenses intended to boost employee morale and in turn increase the efficiency and quality of care provided. Other examples of allowable employee relations expenses are plaques or awards presented to employees for certain achievements or honors. Employee relations cost which discriminates in favor of certain employees, such as employees who are officers, stockholders, related parties, or the highest paid individual(s) in the organization are unallowable. Employee relations costs are limited to a ceiling of $50 per employee eligible to participate per year. If a staff party includes nonemployees, an allocation must be made such that only the portion of costs relating to employees and their families in attendance is reported on the cost report. If a staff party also serves as an open house for promotional purposes, an allocation of costs must be made so that only costs relating to employees and their families in attendance are reported as allowable costs. Entertainment expenses other than those for the benefit of current clients or those for staff employee relations described above are unallowable costs.

(B) Organization costs. Organization costs are those costs directly incident to the creation of a corporation or other form of business necessary to provide contracted services. These costs are intangible assets in that they represent expenditures for rights and privileges which have a value to the business enterprise.

(i) Allowable organization costs include, but are not limited to, legal fees incurred (such as drafting documents) in establishing the corporation or other organization, necessary accounting fees, and fees paid to states for incorporation. Allowable organization costs must be amortized over a period of not less than 60 consecutive months, beginning with the first month in which services are delivered to the first client.

(ii) The following types of costs are considered unallowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, reorganization costs, and stockholder servicing costs. If the business or corporation never commences actual operations, the organization costs are unallowable.

(C) Franchise fees.

(i) Allowable franchise fees. Allowable franchise fees include those costs related to actual goods, supplies, and services received in return for fees paid to a company for the right to sell its goods and/or services in a specific territory.

(ii) Unallowable franchise fees. Franchise fees based upon percentages of revenues and/or sales are unallowable costs. Franchise fees based upon goodwill are unallowable, with goodwill being that intangible, salable asset arising from the reputation of a business and its relationship with its customers.

(D) Startup costs. 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 in §409.10(b)(7) of this title (relating to Specification for Allowable and Unallowable Costs). Any costs that are properly identifiable as organization costs or capitalizable as 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 or corporation never commences actual operations or if the new contract/program never delivers services, the startup costs are unallowable.

(i) For a newly-formed business, startup costs should be accumulated up to the time the business begins (that is, when services are delivered to the first client/customer). Amortization of startup cost for a newly-formed business begins the month the business begins. In the event that a newly-formed business is established for the direct purpose of contacting with the state for delivery of client care services, startup costs should be accumulated up to the time the contract is effective or the time the first client receives services, whichever comes first, with amortization of startup costs beginning the same month.

(ii) For a new contract or program implemented by an existing business, startup costs are related only to the

development of the provider's ability to furnish services according to the standards of the new contract/program and should be accumulated up to the time the first client receives services according to the contract/program standards or the effective date of the contract, whichever occurs first. Amortization of startup costs for a new contract/program implemented by an existing business begins the month in which the first client receives services according to contract/program standards or the effective date of the contract, whichever occurs first. If a contracted provider intends to prepare all portions of its entire program at the same time, startup costs for all portions of the program should be accumulated in a single account and should be amortized beginning either when the first client is admitted or the effective date of the contract, whichever occurs first. However, if a contracted provider intends to prepare portions of its program on a piecemeal basis, startup cost should be capitalized and amortized separately for the portion(s) of the provider's program prepared during the different time periods. For example, a newly-formed corporation opens an ICF/MR, serving its first client on April 4, 1995. Startup costs would be those costs incurred prior to April 4, 1995, which meet the above definition of startup costs. Amortization of the startup costs for this newly-formed business would begin April 1995. If this same corporation received a contract with TDMHMR to provide Home and Community Based Services (HCS) effective October 1, 1995, and if the corporation served its first HCS client on November 5, 1995, startup costs would be those costs incurred to be able to deliver services according to HCS standards. If the corporation was in compliance with HCS standards from its beginning (April 1995), no new startup costs would be allowable for amortization as a result of the implementation of the new HCS contract by the existing corporation. On the other hand, if the corporation was required to incur additional costs to bring the operation up to the HCS standards, those startup costs incurred prior to October 1, 1995, (since the contract effective date occurred prior to serving the first HCS client) would be amortized beginning with October 1995.

(E) Research and development costs. Research and development costs, including, but not limited to, telephone costs, travel costs, attorney fees, and staff salaries, must be segregated into separate, individual accounts for each venture in the contracted provider's general ledger. Should such a "venture" result in a contract for a program, the allowable research and development costs would be incorporated as startup costs for that program. Research and development costs related to states other than Texas are not allowable costs for any allocation to any contracted program.

(F) Medical supplies and medical costs. In general, medical supplies and equipment required by the Occupational Safety and Health Administration (OSHA), used for universal health and safety precautions, or otherwise required to meet contracted program requirements are allowable costs. Refer to §409.19 of this title (relating to Program-Specific Allowable and Unallowable Costs) to determine program requirements for medical supplies and medical costs.

(G) Fines and penalties. Fines and penalties for violations of regulations, statutes, and ordinances of all types are unallowable costs. Penalties or charges for late payment of taxes, utilities, mortgages, loans or insufficient banking funds are unallowable costs.

(H) Business expenses not directly related to contracted services. Business expenses not directly related to contracted services, including business investment activities, stockholder and public relations activities, and farm and ranch operations (unless farm and ranch operations are specifically allowed by the contracted program as necessary to the provision of client care), are unallowable costs.

(I) Litigation expenses and awards. Unless explicitly allowed elsewhere in this chapter, no court-ordered award of damages or settlements made in lieu thereof or legal fees associated with litigation which resulted in any court-ordered award of damages or settlements made in lieu thereof, or a criminal conviction, are allowable.

(J) Lobbying costs. Lobbying costs are unallowable.

(i) Lobbying means the influencing or attempting to influence an officer or employee of any governmental agency, an officer or employee of Congress or State Legislature, or an employee of a Member of Congress or State Legislature in connection with any of the following actions:

(I) the awarding of any governmental contract;

(II) the making of any governmental grant;

(III) the making of any governmental loan;

(IV) the entering of any cooperative agreement; and

(V) the extension, continuation, renewal, amendment, or modification of any governmental contract, grant, loan or cooperative agreement.

(ii) Costs associated with the following activities are unallowable as lobbying costs:

(I) attempting to influence the outcomes of any governmental election, referendum, initiative, or similar procedure, through in-kind or cash contributions, endorsements, publicity, or similar activity;

(II) establishing, administering, contributing to, or paying the expenses of a political party, campaign, political action committee, or other organization established for the purpose of influencing the outcomes of elections;

(III) attempting to influence the introduction of governmental legislation, the enactment or modification of any pending governmental legislation through communication with any member or employee of the Congress or State Legislature (including efforts to influence state or local officials to engage in similar lobbying activity) or any governmental official or employee in connection with a decision to sign or veto enrolled legislation;

(IV) attempting to influence the introduction of governmental legislation, or the enactment or modification of any pending governmental legislation by preparing, distributing or using publicity or propaganda, or by urging members of the general public, or any segment thereof, to contribute to or participate in any mass demonstration, march, rally, fund raising drive, lobbying campaign or letter writing or telephone campaign; and

(V) performing legislative liaison activities, including attendance at legislative sessions or committee hearings, gathering information regarding legislation, and analyzing the effect of legislation, when such activities are carried on in support of or in knowing preparation for an effort to engage in unallowable lobbying.

(iii) The cost to contracted providers or their staff to attend meetings with the staff of state agencies or to attend public hearings or advisory committee meetings held by state agencies which are involved in the regulation of contracted client care in the program which

they are contracting and which meetings do not meet the definition of lobbying stated above, are not considered lobbying and are therefore allowable costs.

(iv) Expenses relating to lobbying are unallowable including salaries, benefits, and payroll taxes for staff performing these activities. If a staff member performs these activities along with allowable activities, a portion of that staff member's salary must be allocated to the unallowable activities and as such not be reported on the cost report.

(K) Direct reimbursements. Any expenses directly reimbursable to the contracted provider which are considered outside the reimbursement payment system are unallowable costs, including, but not limited to, costs associated with Medicare Part A and B ancillary services. For guidelines on allowability of reporting costs in excess of those reimbursable directly through a voucher payment system, refer to §409.19 of this title (relating to Program-Specific Allowable and Unallowable Costs)

(L) Losses resulting from theft or embezzlement. Losses resulting from theft or embezzlement of property or funds of clients held in trust by the contracted provider are not allowable costs.

(M) A bad debt. A bad debt allowance is a reduction in revenue resulting from unrecoverable revenue in uncollectible accounts created or acquired in the provision of client care. Bad debt as an expense is unallowable.

(N) A charity or courtesy allowance. A charity allowance is a reduction in normal charges due to the indigence of the client or resident. A courtesy allowance is a reduction in charges granted as a courtesy to certain individuals, such as physicians or clergy. These allowances themselves are not costs since the costs of the services rendered are already included in the contracted provider's costs.

(18) Medicaid as payor of last resort. Medicaid is the payor of last resort. Costs for which a recipient had Medicare Part A or B benefits, third party payor benefits, vendor drug coverage, or any other benefits available are not allowable unless the provider can document that a provider of services was not accessible. At a minimum, the documentation must include a list of the providers contacted, date(s) of contact, person to whom spoken, telephone number, and reason for rejection. It is the availability of these benefits to cover the cost, not their utilization, which defines the cost as unallowable.

*§409.11. Revenues.* A provider must report revenues that reflect the activity of the provider and that are directly related to the provision of contracted client care or services. A provider may not report revenues from other programs or activities in which the contracted provider may be engaged.

(1) Revenues should be reported net of charity allowances and courtesy allowances, and bad debt expense.

(2) Any revenues received directly by the provider through a voucher must not be reported on the cost report. Revenues received by the provider from other direct payment systems must not be reported on the cost report unless specifically requested by §409.19 of this title (relating to Program-Specific Allowable and Unallowable Costs) or cost report instructions.

(3) For guidelines in reporting revenue received as a federal grant, refer to §409.10(b)(15) of this title (relating to Specifications for Allowable and Unallowable Costs) and to program-specific rules.

(4) For guidelines in offsetting certain expenses against operating revenues, refer to §409.10(b)(15)(D) of this title (relating to Specifications for Allowable and Unallowable Costs). Interest expenses should be offset against interest income prior to reporting net interest expense or net interest income.

*§409.12. General Reporting and Documentation Requirements, Methods, and Procedures.*

(a) General reporting. Except where otherwise specified under this title, the Texas Department of Mental Health and Mental Retardation (TDMHMR) follows the requirements, methods, and procedures set forth in subsections (b)-(g) of this section to determine costs appropriate for use in the reimbursement determination process.

(b) Cost report requirements. Unless specifically stated in program rules, each provider must submit financial and statistical information on cost report forms provided by TDMHMR or its designee, or on facsimiles which are formatted according to TDMHMR or its designee's specifications and are pre-approved by TDMHMR or its designee staff, or electronically in TDMHMR-prescribed format in programs where these systems are operational. The cost reports must be submitted to TDMHMR or its designee in a manner prescribed by TDMHMR. The cost reports must be prepared to reflect the activities of the provider during the fiscal year specified by the cost report. Cost reports or other special surveys or reports may be required for other periods at the discretion of TDMHMR. Each provider is responsible for accurately completing any cost report or other special survey or report submitted to TDMHMR or its designee.

(1) Accounting methods. All financial and statistical information submitted on cost reports must be based upon the accrual method of accounting, except where otherwise specified in §409.9 and §409.10 of this title (relating to General Principles of Allowable and Unallowable Costs, and Specifications for Allowable and Unallowable Costs) and in the case of governmental entities operating on a cash or modified accrual basis. For cost-reporting purposes, accrued expenses must be incurred during the cost reporting period and must be paid within 180 days after the end of that cost reporting period. Accrued revenues must be for services performed during the cost reporting period and do not have to be received within 180 days after the end of that cost reporting period in order to be reported as revenues for cost-reporting purposes. Except as otherwise specified by the cost determination process rules of this chapter, cost-report instructions, or policy clarifications, cost reports should be prepared consistent with generally accepted accounting principles (GAAP), which are those principles approved by the American Institute of Certified Public Accountants (AICPA). Internal Revenue Service (IRS) laws and regulations do not necessarily apply in the preparation of the cost report. In cases in which cost reporting rules conflict with GAAP, IRS, or other authorities, TDMHMR rules take precedence for provider cost-reporting purposes.

(2) Recordkeeping and adequate documentation. There is a distinction between noncompliance in recordkeeping, which equates with unauditability of a cost report and constitutes an administrative contract violation, and a provider's inability to provide adequate documentation, which results in disallowance of relevant costs. Each is discussed in the following paragraphs.

(A) Recordkeeping. Each provider must maintain records according to the requirements stated in Chapter 401 Subchapter E of this title (relating to Contractor's Records) and according to the prescribed chart of accounts, when available. Providers must ensure that records are accurate and sufficiently detailed to support the legal, financial, and other statistical information contained in the cost report. Failure to maintain all workpapers and any other records that support the information submitted on the cost report relating to all allocations, cost centers cost or statistical line items, surveys, and schedules constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsider-

ation and/or appeal processes are specified in §409. 18 of this title (relating to Administrative Contract Violations) for all other programs.

(B) Adequate documentation. To be allowable, the relationship between reported costs and contracted services must be clearly and adequately documented. Adequate documentation consists of all materials necessary t, demonstrate the relationship of personnel, supplies, and services to the provision of contracted client care or the relationship of the central office to the individual service delivery entity level. These materials may include, but are not limited to, accounting records, invoices, organizational charts, functional job descriptions, other written statements, and direct interviews with staff, as deemed necessary by the designated auditors to perform required tests of reasonableness, necessity, and allowability. For the 1996 cost report only, TDMHMR or its designee will accept documentation to retrospectively support expenses which were incurred in the provider's 1996 fiscal year prior to the adoption of these rules and reported on the provider's 1996 cost report. This supportive documentation must not be dated later than June 30, 1996.

(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 during 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 the employee, including vacation and sick leave.

(ii) To support the existence of a loan, the provider must have available a signed copy of the loan contract which contains the pertinent terms of the loan, such as amount, rate of interest, method of payment, due date, and collateral. The documentation must include an explanation for the purpose of the loan and an audit trail must be provided showing the use of the loan proceeds. Evidence of systematic interest and principal payments must be available and supported by the payback schedule in the note or amortization schedule supporting the note. Documentation must also include substantiation of any costs associated with the securing of the loan, such as broker's fees, due diligence fees, lender's fees, attorney's fees, etc. To document allowable interest costs associated with related party loans, the provider is required to maintain documentation verifying the prime interest rate in accordance with §409.10(b)(8)(C) of this title (relating to Specifications for Allowable and Unallowable Costs) for a similar type of loan as of the effective date of the related party loan.

(iii) For transportation equipment, a mileage log is not required if the equipment is used solely (100%) for provision of contracted client services in accordance with program requirements in delivering one type of contracted care. However, the contracted provider must have a written policy which states that the equipment is restricted to that use and that policy must be followed. For transportation equipment that is used for several purposes (including for personal use) or multiple programs or across various business components, mileage logs must be maintained. Personal use includes, among other things, driving to and from a personal residence. At a minimum, mileage logs must include for each individual trip the date, the time of day (beginning and ending), driver, persons in the vehicle, trip mileage (beginning, ending, and total), purpose of the trip, and the allocation centers (the departments, programs, and/or business entities to which the trip costs should be allocated) . Flight logs must include dates, mileage, passenger lists, and destinations, along with any other information demonstrating the purpose of the trips so that a relationship to contracted client care in Texas can be determined. Documentation substantiating that private aircraft travel expenses are not greater than ground transportation or commercial alternatives includes written documentation to support calculations of mileage reimbursement, staff per diem costs, staff salary costs for time during the trip and at the terminal/station, rental care costs, commercial airplane fare, and any other costs associated with the ground transportation/commercial alternatives.

(iv) To substantiate the allowable cost of leasing a luxury vehicle as defined in §409.10(b)(7)(C)(i) of this title (relating to Specifications for Allowable and Unallowable Costs), the provider must obtain at the time of the lease a separate quotation establishing the monthly lease costs for the base amount allowable for cost-reporting purposes as specified in §409.10(b)(7)(C)(i) of this title (relating to Specifications for Allowable and Unallowable Costs). If the lease of the luxury vehicle occurred prior to January 1, 1996, then the provider must obtain the separate quotation prior to submitting its 1996 cost report in order for the allowable costs to be reported on the cost report. Without adequate documentation to verify the allowable lease costs of the luxury vehicle, the reported costs shall be disallowed.

(v) For adequate documentation purposes, a written description of each cost allocation method must be maintained which includes, at a minimum, a clear and understandable explanation of the numerator and denominator of the allocation ratio described in words and in numbers, as well as a written explanation of how and to which specific business components the remaining percentage of costs were allocated.

(vi) To substantiate the allowable cost for staff training as defined in §409.10(b)(12)(A) of this title (relating to Specifications for Allowable and Unallowable Costs), the provider must maintain a description of the training verifying that the training pertained to contracted client care-related services or quality assurance. At a minimum, a program brochure describing the seminar or a conference program with description of the workshop must be maintained. The documentation must provide a description clearly demonstrating that the seminar or workshop provided training pertaining to contracted client care-related services or quality assurance.

(vii) Documentation regarding the allocation of costs related to noncontracted services, as specified in §409.9(j)(2) of this title (relating to General Principles of Allowable and Unallowable Costs), must be maintained by the provider. At a minimum, the provider must maintain written records verifying the number of units of noncontracted services provided during the provider's fiscal year, along with adequate documentation supporting the direct and allocated costs associated with those noncontracted services.

(viii) Adequate documentation to substantiate legal, accounting, and auditing fees must include, at a minimum, the amount of time spent on the activity, a written description of the activity performed which clearly explains to which business component the cost should be allocated, the person performing the activity, and the hourly billing amount of the person performing the activity. Other legal, accounting, and auditing costs, such as photocopy costs, telephone costs, court costs, mailing costs, expert witness costs, travel costs, and court reporter costs, must be itemized and clearly denote to which business component the cost should be allocated.

(ix) Providers who self insure for all or part of their employee-related insurance costs, such as health insurance, and workers' compensation costs, must use one of the two following methods for determining and documenting the provider's allowable costs under the cost ceilings and any carry forward as described in §409.10(b)(10)(E) of this title (relating to Specifications for Allowable and Unallowable Costs).

(I) Providers may obtain and maintain each fiscal year's documentation to establish what their premium costs would have been had they purchased commercial insurance for total coverage. The documentation should include, at a minimum, bids from two commercial carriers Bids must be obtained no less frequently than every three years.

(II) If providers choose not to obtain and maintain commercial bids as described in subclause (I) of this clause, providers may claim as an allowable cost the health insurance actual paid claims incurred on behalf of the employees that does not exceed 10% of the payroll for employees eligible for receipt of this benefit. In addition, providers may claim as an allowable cost the workers' compensation actual paid claims incurred on behalf of the employees, an amount each cost report period not to exceed 10% of the payroll for employees eligible for receipt of this benefit.

(III) Providers who self insure must also maintain documentation that supports the amount of claims paid each year and any allowable costs to be carried forward to future cost-reporting periods.

(x) Providers who self insure for all or part of their coverage for non-employee-related insurance, such as malpractice insurance, comprehensive general liability, and property insurance, must maintain documentation for each cost-reporting period to establish what their premium costs would have been had they purchased commercial insurance for total coverage The documentation should include, at a minimum, bids from two commercial carriers. Bids must be obtained no less frequently than every three years Providers who self insure must also maintain documentation that supports the amount of claims paid each year and any allowable costs to be carried forward to future cost-reporting periods. Governmental providers must document the existence of their claims management and risk management programs.

(xi) Regarding compensation of owners and related parties, providers must maintain the following documentation, at a minimum, for each owner or related party: a detailed written description of actual duties, functions, and responsibilities; documentation substantiating that the services performed are not duplicative of services performed by other employees; time sheets or other documentation verifying the hours and days worked; the amount of total compensation paid for these duties, with a breakdown detailing regular salary, overtime, bonuses, fringe 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; and a detailed allocation worksheet indicating how the total compensation was allocated across business components receiving the benefit of these duties.

(I) Regarding bonuses paid to owners and related parties, the provider must maintain clearly defined bonus policies in its written agreements with employees or in its overall employment policy. At a minimum, the documentation must include the basis for distributing the bonuses, how the amount of each bonus is calculated, who received bonuses, whether the persons receiving bonuses are owners, related parties, or arm's-length employees, and the bonus amount received by each individual.

(II) Regarding fringe benefits provided to owners and related parties, the provider must maintain clearly defined benefit policies in its written agreements with employees or in its overall employment policy At a minimum, the documentation must include the basis for eligibility for each type of fringe benefit available, who is eligible to receive each type of fringe benefit, who actually receives each type of fringe benefit, whether the persons receiving each type of benefit are owners, related parties, or arm's-length employees, and the amount of each fringe benefit received by each individual.

(xii) Regarding all forms of compensation, providers must maintain documentation for each employee which clearly identifies each compensation component, including regular pay, overtime pay, incentive pay, mileage reimbursements, bonuses, sick leave, vacation, other paid leave, deferred compensation, retirement contributions, provider-paid instructional courses, health insurance, disability insurance, life insurance, and any other form of compensation. Types of documentation would include insurance policies; provider benefit policies; records showing paid leave accrued and taken; documentation to support hours (regular and overtime) worked and wages paid; and mileage logs or other documentation to support mileage reimbursements and travel allowances. For accrued fringe benefits, the documentation must clearly identify the period of the accrual. For example, if an employee accrues two weeks of vacation during 19x1 and receives the corresponding vacation pay during 19x3, that employee's compensation documentation for 19x3 should clearly indicate that the vacation pay received had been accrued during 19x1.

(xiii) Management fees paid to related parties must be documented as to the actual costs of the related party for materials, supplies, and services provided to the individual provider, and upon which the management fees were based. If the cost to the related party includes owner compensation or compensation to related parties, documentation guidelines for those costs are specified in clause (xi) of this subparagraph. Documentation must be maintained that indicates stated objectives, periodic assessment of those objectives, and evaluation of the progress toward those objectives.

(xiv) For central office and/or home office costs, documentation must be maintained that indicates the organization of the business entity, including position, titles, functions, and compensation. For multi-state organizations, documentation must be maintained that clearly defines the relationship of costs associated with any level of management above the individual Texas contracted entity which are allocated to the individual Texas contracted entity.

(xv) Documentation regarding depreciable assets includes, at a minimum, historical cost, date of purchase, depreciable basis, estimated useful life, accumulated depreciation, and the calculation of gains and losses upon disposal.

(xvi) Providers must maintain documentation clearly itemizing their employee relations expenditures. For employee entertainment expenses, documentation must show the names of all persons participating, along with classification of the person attending, such as employee, nonemployee, owner, family of employee, client, or vendor.

(xvii) Adequate documentation substantiating the offsetting of grants and contracts from federal, state, or local governments prior to reporting either the net expenses or net revenue must be maintained by the provider. As specified in §409.10(b)(15) of this title (relating to Specifications for Allowable and Unallowable Costs), such offsetting is required prior to reporting on the cost report. The provider must maintain written documentation as to the purpose for which the restricted revenue was received and the offsetting of the restricted revenue against the allowable and unallowable costs for which the restricted revenue was used.

(xviii) During the course of an audit or an audit desk review, the provider must furnish any reasonable documentation requested by the auditors within ten working days of the request or a later date as specified by the auditors. If the provider does not present the requested material within the specified time, the audit or audit desk review is closed, and the depart-

ment automatically disallows the costs in question

(xix) Any expense which cannot be adequately documented or substantiated is disallowed. TDMHMR is not responsible for the contracted provider's failure to adequately document and substantiate reported costs.

(xx) Any cost report which is determined unauditable through a field audit or which cannot have its costs verified through a desk review will not be used in the reimbursement determination process

(3) Cost report and methodology certification. Providers must certify the accuracy of cost reports submitted to TDMHMR or its designee in the format specified by TDMHMR. Providers may be liable for civil and/or criminal penalties if the cost report is not completed according to TDMHMR requirements or is determined to contain misrepresented or falsified information. Cost report preparers must certify that they received published reimbursement methodology rules regarding allowable and unallowable costs, that they read the reimbursement methodology and cost report instructions, and that they understand that the cost report must be prepared in accordance with the methodology rules and cost report instructions Not all persons who contributed to the completion of the cost report must sign the certification page However, the certification page must be signed by a reasonable party with direct knowledge of the preparation of the cost report A person with supervisory authority over the preparation of the cost report who reviewed the completed cost report may sign the certification page in addition to the actual preparer.

(4) Requirements for Cost Report Completion.

(A) A completed cost report must

(i) be completed according to the cost determination rules of this chapter, program-specific allowable and unallowable rules, cost report instructions, and policy clarifications,

(ii) contain a signed, notarized, original certification page,

(iii) be legible with entries in sufficiently dark print to be photocopied,

(iv) contain all pages and schedules,

(v) be submitted on the proper cost report form,

(vi) be completed using the correct cost reporting period, and

(vii) contain a copy of the state-issued cost report training certificate, beginning with the 1996 cost report.

(B) Providers are required to report amounts on the appropriate line items of the cost report pursuant to guidelines established in the methodology rules, cost report instructions, and/or policy clarifications. Placement on the cost report of an amount which was determined to be inaccurately placed constitutes an administrative contract violation. Refer to program-specific reimbursment methodology rules cost report instructions, and/or policy clarifications for guidelines used to determine placement of amounts on cost report line items. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §409.18 (Administrative Contract Violations) for all other programs.

(C) Failure to file a completed cost report by the cost report due date constitutes an administrative contract violation. In the case of a contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §409.18 of this title (relating to Administrative Contract Violations) for all other programs

(D) TDMHMR may excuse providers from the requirement to submit a cost report. Exceptions are granted by TDMHMR as described by the program specific reimbursement methodology rules. Providers who are excused from cost report submission will receive written notice from TDMHMR verifying that an exception has been granted.

(5) Cost report year. A provider's cost report year must coincide with the provider's fiscal year as used by the provider for reports to the Internal Revenue Service (IRS). Providers are responsible for reporting to TDMHMR any change in their IRS fiscal year and subsequent cost report year by submitting written notification of the change to TDMHMR along with supportive IRS documentation. TDMHMR must be notified of the provider's change in IRS fiscal year no later than 30 days following the provider's receipt of approval of the change from the IRS.

(6) Failure to report allowable costs. TDMHMR is not responsible for the contracted provider's failure to report allowable costs; however any omitted costs which are identified during the desk review or audit process will be included in the cost report or brought to the attention of the provider to correct by submitting an amended cost report.

(c) Cost report due date.

(1) Providers must submit cost reports to TDMHMR or its designee no later than 90 days following the end of the provider entity's fiscal year or 90 days from the transmittal date of the cost report forms, whichever due date is later.

(2) TDMHMR may grant extensions of due dates for good cause. A good cause is defined as a circumstance which the provider could not reasonably be expected to control and for which adequate advance planning and organization would not have been of any assistance. Providers must submit requests for extensions in writing to TDMHMR Requests for extensions must be received by TDMHMR or its designee prior to the cost report due date. Designated staff will respond in writing to requests within 15 days of receipt.

(3) TDMHMR may require additional financial and other statistical information, in the form of special surveys or reports, to ensure the fiscal integrity of the program. Providers must submit such additional information and/or special surveys or reports to TDMHMR or its designee upon request by the date specified by TDMHMR or its designee in its transmittal or cover letter to the special survey, report, or request for additional information.

(d) Amended cost report due dates. TDMHMR accepts submittal of provider-initiated or requested amended cost reports as follows.

(1) Provider-initiated amended cost reports must be received no later than the date from subparagraph (A)(B) of this paragraph, whichever occurs first. Amended cost reports received after this date have no effect on the reimbursement determination. Amended cost report information that cannot be verified will not be used in reimbursement determinations. Provider-initiated amended cost reports must be received no later than the earlier of:

(A) 60 days after the original due date of the cost report, or

(B) for Medicaid programs, 30 days prior to the public hearing on proposed reimbursement or reimbursement parameter amounts; and for non-Medicaid programs 45 days, prior to TDMHMR board meeting to approve reimbursement or reimbursement parameter amounts.

(2) TDMHMR-required amendments to the cost reports must be received on or before the date specified by TDMHMR or its designee in its request for the amended cost report. 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 subsection (b)(4)(C) of this section.

(e) Field audit standards. TDMHMR or its designee performs cost report field audits in a manner consistent with Government Auditing Standards issued by the Comptroller General of the United States.

(f) Cost of out-of-state audits. As specified in §409.13 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), TDMHMR or its designee conducts desk reviews of all cost reports not selected for field audit. TDMHMR or its designee also conducts field audits of provider records and cost reports. Although the number of field audits performed each year may vary, TDMHMR seeks to maximize the number of field audited cost reports available for use in its cost projections. Whenever possible, the records necessary to verify information submitted on cost reports, including related party transactions and other business activities engaged in by the provider, must be accessible to the designated audit staff within the State of Texas. When records are not available to the designated audit staff within the State of Texas, the provider must pay the actual costs for the designated audit staff to travel and review the records out-of-state. Failure to reimburse TDMHMR for these costs within 60 days of the request for payment constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §409.18 of this title (relating to Administrative Contract Violations) for all other programs.

(g) Public hearings.

(1) Uniform reimbursements. For Medicaid programs where reimbursements are uniform by class of service and/or provider type, TDMHMR will hold a public hearing on proposed reimbursements before the of Mental Health and Mental Retardation approves reimbursements. The purpose of the hearing is to give interested parties an opportunity to comment on TDMHMR's proposed reimbursements. Notice of the hearing will be provided to the public. The notice of the public hearing will identify the name, address, and telephone number to contact for the materials pertinent to the proposed reimbursements. At least ten working days before the public hearing takes place, material pertinent to the proposed statewide uniform Medicaid reimbursements will be made available to the public. This material will include the proposed reimbursements, the inflation adjustments used to determine them, and the impact on reimbursements of the major cost limits. This material will be furnished to anyone who requests it. After the public hearing, if negative comments are received, a written summary of the comments made during the public hearing will be presented to the Texas Board of Mental Health and Mental Retardation.

(2) Contractor-specific reimbursements. In programs where reimbursements are contractor-specific, TDMHMR will hold a public hearing on the reimbursement determination parameter dollar amounts (e. g., ceilings, floors, or program reimbursement formula limits) before the Texas Board of Mental Health and Mental Retardation approves parameter dollar amounts. The purpose of the hearing is to give interested parties an opportunity to comment on TDMHMR's proposed reimbursement parameter dollar amounts. Notice of the public hearing will be provided to the public. The notice of the public hearing will identify the name, address, and telephone number to contact for the materials pertinent to the proposed reimbursement parameter dollar amounts. At least 10 working days before the public hearing takes place, material pertinent to the proposed reimbursement parameter dollar amounts will be made available to the public. This material will include the proposed reimbursement parameter dollar amounts, the inflation adjustments used to determine them, and the impact on the reimbursement parameter dollar amounts of the major cost limits. This material will be furnished to anyone who requests it. After the public hearing, if negative comments are received, a written summary of the comments made during the public hearing will be presented to the board.

(h) When insufficient cost data are unavailable. If an insufficient number of accurate, full-year cost reports is submitted, as would occur with a new program, or if there are insufficient available data, as would occur in changes in program design, changes in the definition of units of service or changes in regulations or program requirements reimbursements may be based on a pro-forma analysis by TDMHMR or its designee staff. A pro-forma analysis is defined as an item-by-item, or classes-of-items, calculation of the reasonable and necessary expenses for a provider to operate. The analysis may involve assumptions about the salary of an administrator or program director, staff salaries, employee benefits and payroll taxes, building depreciation, mortgage interest, contracted client care expenses, and other building or administration expenses. To determine the cost per unit of service, TDMHMR adds all the pro-forma expenses and divides the total by the estimated number of units of service that a fully operational provider is likely to provide. The pro-forma analysis is based on available information that is determined to be sufficient, accurate, and reliable by TDMHMR or its designee staff, including valid cost-report data and survey data. The pro-forma analysis is conducted in a way that ensures that the resultant reimbursements are sufficient to support the requirements of the contracted program. When TDMHMR or its designee staff determine that sufficient and reliable cost-report data have become available, the pro-forma reimbursement determination may be replaced with a process based on cost reports.

*§409.13. Basic Objectives and Criteria for Audit and Desk Review of Cost Reports.*

(a) The Texas Department of Mental Health and Mental Retardation (TDMHMR) or its designee conducts desk reviews and field audits of provider cost reports in order to ensure that all financial and statistical information reported in the cost reports conforms to all applicable rules and instructions. Cost reports not completed according to instructions or rules in accordance with §409.12(b)(4) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures) constitutes a contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §409.18 of this title (relating to Administrative Contract Violations) for all other programs. TDMHMR may require supporting documentation other than that contained in the cost report to substantiate reported information.

(b) The basic objective of audits and desk reviews is to verify that each provider's cost report:

(1) displays financial and other statistical information in the format required by TDMHMR or its designee;

(2) reports expenses in conformity with TDMHMR's lists of allowable and unallowable costs;

(3) follows generally accepted accounting principles, except as otherwise specified in TDMHMR'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

(4) is completed in accordance with each program's cost report instructions and rules.

(c) TDMHMR or its designee verifies the information specified in subsection (b) of this section by:

(1) comparing each provider's reported costs to:

(A) past patterns of expenditures for similar services;

(B) the results of previous field audits;

(C) normal operating cost relationships; and

(D) industry average costs, when available;

(2) reviewing each provider's reported costs for:

(A) reported unallowable costs;

(B) omitted allowable costs, if discovered during the course of the audit or desk review; and

(C) understated or overstated allowable costs, if discovered during the course of the audit or desk review;

(3) checking for completion of required information;

(4) checking the format for proper cost classification;

(5) checking for mathematical accuracy; and

(6) adjusting the cost report, or notifying the provider that research and/or corrections are required.

(d) In accordance with methodology rules, cost report instructions or policy clarifications, TDMHMR or its designee staff may reassign allowable costs to the appropriate line items of a cost report.

(e) TDMHMR seeks to maximize the number of field audited cost reports available for use in its cost projections. In addition to cost reports selected for field audit based upon risk analysis, other specific criteria and random sampling, TDMHMR or its designee may conduct field audits of cost reports that show unusual fluctuations or trends in costs or other statistics. TDMHMR or its designee may also conduct field audits when desk reviews are insufficient to verify the accuracy of reported costs.

(f) Each provider entity or its designated agent(s) must allow access to any and all records necessary to verify information submitted to TDMHMR or its designee on cost reports. This requirement includes records pertaining to related party transactions or other business activities engaged in by the provider. Failure to allow access to records constitutes a contract violation. In the case of a contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §409.18 of this title (relating to Administrative Contract Violations) for all other programs.

(g) A contracted provider may request an informal review, and subsequently an appeal, of a desk review or field audit disallowance in accordance with §409.17 of this title (relating to Informal Reviews and Formal Appeals).

*§409.14. Notification of Exclusions and Adjustments.*

(a) The Texas Department of Mental Health and Mental Retardation (TDMHMR) or its designee notifies providers of exclusions and adjustments to reported expenses made during the desk reviews and field audits of cost reports. TDMHMR or its designee mails notices of desk-review exclusions and adjustments within 15 working days after finalization of the desk-review by the designated auditors. The notice consists of a letter to the provider and desk-review adjustment sheet(s) that specifies:

(1) the line-items on the cost report that have been adjusted or excluded;

(2) the amount of each adjustment or exclusion; and

(3) the principal reason for each adjustment or exclusion.

(b) TDMHMR or its designee also furnishes providers with written reports of the results of field audits. Each field audit report is mailed within 30 days after the final exit interview with the provider. An exit interview is final when the designated audit staff have received, reviewed, and analyzed all documentation from the provider pertinent to the scope of the audit. The field audit report consists of a professional report prepared by the designated audit staff to enumerate the results of a field audit. Each field audit report includes a specification of:

(1) cost-report line-items that have been adjusted or excluded;

(2) the amount of each adjustment or exclusion; and

(3) the principal reason for each adjustment or exclusion.

(c) TDMHMR or its designee mails field audit reports and notices of desk-review exclusions and adjustments to the addresses that providers have given TDMHMR or its designee as their standard mailing addresses. However, if a provider submits a written request for TDMHMR or its designee to send a field audit report or notice of desk-review exclusions and adjustments to an address other than the provider's standard mailing address, the rate analysis staff may do so.

(d) A provider may also submit a written request for TDMHMR or its designee to provide additional information about exceptions and adjustments to the provider's cost report, including citations of the laws or regulations that constitute the grounds for the exceptions and adjustments. TDMHMR or its designee must comply with such requests in writing within 30 calendar days.

*§409.15. Determination of Inflation Indices.*

(a) Function and types of indices. In order to account for cost inflation between the reporting period and the prospective reimbursement period, TDMHMR or its designee makes adjustments to allowable costs based on inflation factors or multipliers calculated from appropriate inflation indices. TDMHMR or its designee retains the discretion, on a program by program basis, to exercise the following options in order to obtain appropriate inflation indices.

(b) Contracting for inflation index development. TDMHMR may contract with a reputable and experienced independent professional firm to develop appropriate optional indices for Texas. If TDMHMR obtains such indices under contract, the agency retains the option, on a program by program basis, of utilizing these indices and/or those described in the remainder of this section, either separately or in combination, for reimbursement determination purposes.

(c) Cost inflation indices. TDMHMR or its designee may utilize a general cost inflation index obtained from a reputable independent professional source and, where TDMHMR or its designee staff deems appropriate and pertinent data are available, to develop and/or utilize several item-specific and program-specific inflation indices, as follows.

(d) General cost inflation index. TDMHMR or its designee uses the Implicit Price Deflator-Personal Consumption Expenditures (IPD-PCE) as the general cost inflation index. The IPD-PCE is a nationally recognized measure of inflation published by the Bureau of Economic Analysis of the U.S. Department of Commerce. To project or inflate costs from the reporting period to the prospective reimbursement period, TDMHMR or its designee uses the lowest feasible IPD-PCE forecast consistent with the forecasts of nationally recognized sources available to TDMHMR or its designee at the time proposed reimbursement is prepared for public dissemination and comment.

(e) Item-specific and program-specific inflation indices. TDMHMR or its designee may use specific indices in place of the general cost inflation index specified in subsection (d) of this section when appropriate item-specific or program-specific cost indices are available from TDMHMR cost reports or other surveys, other Texas state agencies or independent private

sources, or nationally recognized public agencies or independent private firms, and TDMHMR or its designee has determined that these specific indices are derived from information that adequately represents the program(s) or cost(s) to which the specific index is to be applied. For example, TDMHMR or its designee may use specific indices pertaining to cost items such as payroll taxes, key professional and non-professional staff wages, and other costs subject to specific federal or state limits. The specific indices that TDMHMR or its designee may use include the following.

(1) Federal Insurance Contributions Act (FICA) or Social Security taxes, including Old Age, Survivors, and Disability Insurance (OASDI) and Medicare taxes, are set by Federal statute. The inflation index for these taxes is the average tax rate, or average tax per payroll dollar, during the prospective reimbursement period divided by the average tax rate, or average tax per payroll dollar, during each provider's reporting period. If tax rates for the prospective reimbursement period are not available at the time proposed reimbursement is prepared for public dissemination and comment, projections are based on the compounded annual rate of change in these tax rates from the most recent consecutive two-year period for which data are available at the time proposed reimbursement is determined.

(2) For providers covered by standard Workers' Compensation Insurance (WCI), the WCI index is based on rate figures by job classification made available by the Texas Department of Insurance. TDMHMR or its designee determines which available job classification category most closely tracks WCI costs in each program and calculates a historical WCI inflation index based on the tax rates for each pertinent category. The WCI inflation index is the average insurance rate during the prospective reimbursement period divided by the average insurance rate during each provider's reporting period. If basic insurance rates for the prospective reimbursement period are unknown at the time proposed reimbursement is calculated for public dissemination and comment, projections are based on the compounded annual rate of change in WCI insurance rates from the most recent consecutive two-year period for which data are available at the time reimbursement is calculated. For providers participating in other types of workers' compensation plans deemed allowable under other pertinent sections of TDMHMR rules, the WCI index may be based on projected rates for each provider. Such projections must be developed by independent professional entities and must be based on sound actuarial principles.

(3) Except where indicated otherwise for specific programs, the unemployment tax inflation index is based on unemployment insurance payroll taxes in accordance with the Federal Unemployment Tax Act (FUTA) and the Texas Unemployment compensation act (TUCA) rates obtained from the Texas Employment Commission (TEC). Because the TUCA component of the tax rate may be contractor-specific, TDMHMR or its designee obtains the average effective rates for the lowest available Standard Industrial Classification (SIC) code pertinent to each program. The unemployment tax inflation index is the average tax rate during the prospective reimbursement period divided by the average tax rate during each provider's reporting period. If the average tax rate for the prospective reimbursement period is unknown at the time proposed reimbursement is calculated for public dissemination and comment, projections are based on the compounded annual rate of change in FUTA/TUCA tax rates from the most recent consecutive two year period for which data are available at the time reimbursement is calculated. When changes occur in such factors as payroll limits to which tax rates apply, TDMHMR or its designee may make appropriate adjustments in projections to reflect new limits and related factors affecting the impact of new limits, such as employee turnover rates.

(4) Inflation factors for professional staff wages and salaries are based on wage and salary survey data pertaining to specific types of professional staff in Texas when reliable data of this kind are available for specific or comparable programs. Projections from the cost reporting period to the reimbursement period are based on discernible trends or experience as evidenced by the most recent reliable data available at the time proposed reimbursement is prepared for public dissemination and comment, and take into consideration economic conditions and regulatory changes which may be reasonably anticipated for the reimbursement period.

(5) When reliable wage and salary data pertaining to specific types of staff in Texas are unavailable for specific or comparable programs, inflation factors for professional staff are based on the lowest feasible forecast of the IPD-PCE. Professional wage and benefit inflation rates for state employees are based on state employee wage and salary increases determined by the Texas Legislature.

(6) Inflation factors for key para-professional staff wages and salaries are based on wage and salary survey data pertaining to specific types of staff in Texas when reliable data are available for specific or comparable programs. Projections from the cost reporting period to the prospective reimbursement period are based on discernible trends or recent experience as evidenced by the most recent data available at the time reimbursement is prepared for public dissemination and comment, and take into consideration economic conditions and regulatory changes which may be reasonably anticipated for the reimbursement period. When reliable wage and salary data pertaining to specific types of staff in Texas are unavailable for specific or comparable programs, inflation factors for key para-professional staff are based on the lowest feasible forecast of the IPD-PCE. Nonprofessional or para-professional wage and benefit inflation rates for state employees are based on state employee wage and salary increases determined by the Texas Legislature.

(7) For the Medicaid ICF/MR program, determination of adjustments to historical costs of fixed capital assets are consistent with requirements of the federal Omnibus Budget Reconciliation Act of 1984 (OBRA 1984) and Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 1985). For each program, one of two options is used.

(A) Reimbursement is in the form of a fixed capital asset use fee component of the overall reimbursement, based on facility appraisals, as described in program-specific reimbursement methodology rules.

(B) Reimbursement for fixed capital asset costs is calculated based on historical costs included in the reimbursement component designated in program-specific reimbursement methodology rules. The index used to inflate lease expense and to adjust the allowable depreciation base of assets which have undergone ownership changes is one-half the All-item Urban Consumer Price Index (CPI-U).

(8) The State School ICF-MR program uses the Medical Services component of the CPI-U as the inflation index for the program's comprehensive medical cost center. To project costs from the reporting period to the prospective reimbursement period, the Texas Department of Mental Health and Mental Retardation uses the lowest feasible forecast consistent with the forecasts of nationally recognized sources available to the department at the time proposed reimbursement is prepared for public dissemination and comment.

*§409.16. Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs.*

(a) TDMHMR makes interim adjustments to reimbursement when federal or state laws, rules, regulations, policies, or guidelines are adopted, promulgated, judi-

cially interpreted, or otherwise changed in ways that require most if not all providers to take definitive actions that clearly require changes in expenditures on allowable costs which are, on average over the period the reimbursements in question are scheduled to be in effect, in excess of 2.0% of the reimbursement. In programs where reimbursements are uniform by class of service and/or provider type, this 2.0% rule is applied to the amount above the mean, weighted median or median, depending upon which statistic(s) is (are) used to determine reimbursement for each uniform reimbursement class. In programs where reimbursement is contractor-specific, the 2.0% rule is applied on an individual provider basis; however, interim adjustments are limited to those costs at or below the limits defined at the time reimbursement was determined. TDMHMR proposes adjustments to reimbursement for the above reasons at the earliest feasible opportunity to become effective on the effective date of the federal or state laws, rules, regulations, policies, or guidelines or at the beginning of the nearest calendar quarter for which federal financial participation is available.

(b) TDMHMR may also make interim adjustments to reimbursement when it can be clearly demonstrated that changes in economic factors will result, on average over the period the reimbursement in question is scheduled to be in effect, in allowable cost increases for most if not all providers, over which they have little or no control, in excess of 2.0% of the reimbursement. Such changes in economic factors include, but are not limited to, changes in the rate of wage and price inflation that are not discernible in cost report data or in other data available at the time reimbursement is determined, increases in the number of participating providers or clients with significantly different costs which are demonstrably necessary for provision of care meeting program standards, and changes in TDMHMR's budgetary capabilities. Interim reimbursement adjustments based on changes in economic factors are subject to the same 2.0% rule as those for legal or regulatory reasons, as cited under subsection (a) of this section. Where adjustments are under consideration based on both changes in rules and regulations as described under subsection (a) of this section and economic factors as described under this subsection, the 2.0% rule is based on the combined impact of both types of influences.

(c) In conducting regular, periodic reimbursement reviews and preparing reimbursement adjustments, TDMHMR takes into consideration changes in laws, rules, regulations, policies, guidelines, or economic factors which will have a demonstrable material impact on most provider costs of providing services meeting federal and state standards.

(d) TDMHMR staff recommends to the Texas Board of Mental Health and Mental Retardation statewide uniform reimbursement amounts and reimbursement ceiling amounts determined in accordance with reimbursement determination rules specific to each program. The board may, if necessary, adjust reimbursement amounts downward to operate within the limits of appropriated funds.

(1) TDMHMR staff recommends to the board for contractor-specific reimbursement the parameter dollar amounts in accordance with reimbursement determination rules specific to each program. The board may, if necessary, adjust reimbursement parameter amounts downward to operate within the limits of appropriated funds.

(2) For the Intermediate Care Facilities for the Mentally Retarded (ICF/MR) program subject to the federal Boren Amendment, downward reimbursement adjustments for budgetary reasons may not exceed the amount of any mark-up or margin over projected costs. For the ICF/MR program, this limitation ensures that downward reimbursement adjustments do not reduce reimbursement below the costs which must be incurred by efficient and economic providers meeting federal and state standards.

*§409.17. Informal Reviews and Formal Appeals.*

(a) General provisions.

(1) Definitions. The following words or terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise.

(A) Formal appeal-An administrative hearing requested by an interested party under subsection (d) of this section and conducted in accordance with procedures described in Chapter 409, Subchapter B (relating to Contract Appeals);

(B) Informal review-The informal reexamination of an action or determination by the Texas Department of Mental Health and Mental Retardation (TDMHMR) or its designee under this chapter requested by an interested party and conducted in accordance with subsection (c) of this section.

(C) Interested party-A TDMHMR-contracted provider.

(2) Standing to file informal reviews or formal appeals. Only an interested party has standing to file for an informal review or formal appeal under this section.

(3) Subject matter of informal reviews and formal appeals. An interested party may request an informal review or formal appeal regarding an action by TDMHMR or its designee under §§409.9-409.10 of this title (relating to General Principles of Allowable and Unallowable Costs, Specifications for Allowable and Unallowable Costs, Revenues, and General Reporting and Documentation Requirements, Methods and Procedures), or program-specific allowable or unallowable costs taken specifically in regard to the interested party.

(b) Separation of informal reviews and formal appeals from the reimbursement determination process.

(1) The filing of a request for an informal review or formal appeal under this section does not stay or delay implementation of reimbursement adopted by TDMHMR in accordance with the requirements of this chapter.

(2) Closure of cost report data bases used in the reimbursement determination process and application of results of pending review or appeal. To facilitate the timely and efficient calculation of reimbursement amounts, TDMHMR or its designee closes cost report data bases used in the reimbursement determination process prior to the proposal of reimbursement amounts.

(A) Impact on database of pending informal review or formal appeal. If an informal review or formal appeal is pending at the time the database is closed, the database shall include the interested party's cost report data, including, in the case of an informal review, any adjustments made either in the desk review or field audit; and, in the case of a formal appeal, any adjustment required as a result of the informal review.

(B) Uniform reimbursement.

(i) For programs where reimbursement is uniform by class of service and/or provider type, the cost report database used in reimbursement determination is closed six weeks prior to the public hearing on the proposed reimbursement that is based on the cost report database.

(ii) If an informal review or formal appeal is pending at the time the cost report database is closed, the results of the informal review or formal appeal shall be applied during the next reimbursement determination cycle, if applicable.

(C) Contractor-specific reimbursement.

(i) For programs where reimbursement is contractor-specific the

cost report database is closed ten weeks prior to the end of the reimbursement determination cycle.

(ii) If an informal review or formal appeal is pending at the time the cost report database is closed, the results of the informal review or formal appeal shall be applied to the interested party's payment retroactively to the beginning of the current reimbursement determination cycle. The results of the informal review or formal appeal shall not be applied to the cost report database as a whole or to any other reimbursement amounts influenced by the cost report database as a whole until the next reimbursement determination cycle, if applicable.

(c) Informal review.

(1) An interested party who disputes an action by TDMHMR or its designee under this subchapter may request an informal review under this subsection. The purpose of an informal review is to provide for the informal and efficient resolution of the matters in dispute. An informal review is not a formal administrative hearing, but is a prerequisite to obtaining a formal administrative hearing and is conducted according to the following procedures:

(A) The interested party must contact the Office of Medicaid Administration at TDMHMR in writing within 20 calendar days of the date on the written notification of the exclusions or adjustments to request an informal review.

(B) An interested party must, with its request for an informal review, submit a concise statement of the specific actions or determinations it disputes, its 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.

(2) On receipt of a request for informal review, the Director of the Office of Medicaid Administration at TDMHMR or designee assigns the review to designated staff.

(A) The lead staff member coordinates a review by appropriate staff of the information submitted by the interested party. Staff may request additional information from the interested party, which must be received in writing by the lead staff member within 14 calendar days of the request for additional information. Information received after 14 days may not be used in the panel's written decision unless the interested party receives approval of the lead staff member to submit the information after 14 days.

(B) Within 30 days of the date the request for informal review is received by TDMHMR or its designee or the date additional requested information is received by TDMHMR or its designee, the lead staff member must send the interested party its written decision by certified mail, return receipt requested.

(d) Administrative hearings. An interested party who disagrees with the results of an informal review conducted under subsection (c) of this section may file a formal appeal of the review. The interested party must file a written request for a formal appeal with the Hearings Department, Texas Department of Mental Health and Mental Retardation, P.O. Box 12668, Austin, Texas 78711-2668, within 15 calendar days after receiving the review panel's written decision as specified in subsection (c) of this section. The formal appeal is limited to the issues that were considered in the informal review process. The information from the interested party is limited to the pertinent information considered in the informal review process. TDMHMR conducts formal appeals in accordance with the provisions of Chapter 409, Subchapter B of this title (relating to Adverse Actions). If there is a conflict between the sections in Chapter 409, Subchapter B of this title (relating to Adverse Actions) and the provisions of this subchapter, the provisions of this subchapter prevail.

*§409.18. Administrative Contract Violations.* For details regarding the process for vendor hold and contract cancellation in cases where an ICF/MR fails to submit a cost report or its cost report is determined to be unauditable, refer to §406.62 (relating to Administrative Contract Violations). For other programs whose specific reimbursement methodology rules do not address administrative contract violations, the Texas Department of Mental Health and Mental Retardation (TDMHMR) may take the following actions for administrative contract violations.

(1) TDMHMR grants the provider a compliance period of no more than 30 calendar days to correct a contract violation. At the end of the compliance period, if TDMHMR determines that a contract violation is not corrected, but determines that the provider has made substantial progress toward correcting the contract violation, TDMHMR may grant an additional one-time extension period of up to 15 calendar days.

(2) If the contract violation is not corrected within the compliance period, TDMHMR imposes vendor hold on payments to the provider.

(3) If a contract violation is not corrected within 60 days from the date the provider is placed on vendor hold, TDMHMR may cancel the provider's contract on the 61st day. A provider may request an informal reconsideration and/or an appeal hearing. A request for an informational reconsideration must be made in writing to the commissioner of the Texas Department of Mental Health and Mental Retardation, P.O. Box 12668, Austin, Texas 78711-2668. Regulations governing these appeals are specified in §406.62(f) of this title (relating to Sanction Provisions for Violations of Title XIX ICF/MR Contractual Agreements) and §409.34 of this title (relating to a Request for an Administrative Hearing). If the provider appeals the contract cancellation by TDMHMR and the adverse action is sustained by an administrative law judge or judicial proceeding, the effective date of the contract cancellation is the date the administrative law judge's decision becomes final. Unless otherwise specifically provided for, TDMHMR makes no payment for services provided by the provider after the effective date of the provider's contract cancellation. TDMHMR may continue payments for no more than 30 calendar days from the date TDMHMR cancels or fails to renew a provider's contract if TDMHMR determines that:

(A) reasonable efforts are being made to transfer clients to another provider or to alternate care; and

(B) additional time is needed to effect an orderly transfer of the clients.

*§409.19. Program Specific Allowable and Unallowable Costs.*

(a) Home and Community-Based Services.

(1) Client room and board expenses are not allowable, except for those related to respite care.

(2) The cost of adaptive aids and home modifications are not allowable. Allowable labor costs associated with acquiring adaptive aids and home modifications should be reported in the cost report.

(3) Any item purchased for participants in this program and reimbursed through a voucher payment system is unallowable.

(4) Financial and compliance audits required by TDMHMR as a condition of the provider's contract with TDMHMR are allowable costs.

(b) Home and Community Based-Services OBRA.

(1) Client room and board expenses are not allowable, except for those related to respite care.

(2) The cost of adaptive aids and home modifications is not allowable. Allowable labor costs associated with acquiring adaptive aids and home modifications should be reported in the cost report.

(3) Any item purchased for participants in this program and reimbursed through a voucher payment system is unallowable.

(4) Financial and compliance audits required by TDMHMR as a condition of the provider's contract with TDMHMR are allowable costs.

(c) Case Management for Persons with Mental Retardation or Related Condition

(1) Costs associated with non-covered services are unallowable costs for cost-reporting purposes and should not be reported on the cost report.

(2) Costs associated with emergency and/or discretionary funds which represent persona client expenses are not allowable costs.

(3) Financial and compliance audits required by TDMHMR as a condition of the provider's contract with TDMHMR are allowable costs.

(d) Case Management for Persons with Severe and Persistent Mental Illness.

(1) Costs associated with non-covered services are unallowable costs for cost-reporting purposes and should not be reported on the cost report.

(2) Costs associated with emergency and/or discretionary funds which represent persona client expenses are not allowable costs.

(3) Financial and compliance audits required by TDMHMR as a condition of the provider's contract with TDMHMR are allowable costs.

(e) Diagnostic Services for Persons with Potential of Mental Retardation.

(1) Costs associated with non-covered services are unallowable costs for cost-reporting purposes and should not be reported on the cost report.

(2) Financial and compliance audits required by TDMHMR as a condition of the provider's contract with TDMHMR are allowable costs.

(f) Rehabilitative Services for Persons with Mental Illness

(1) Costs associated with non-covered services are unallowable costs for cost-reporting purposes and should not be reported on the cost report

(2) Costs associated with emergency and/or discretionary funds which represent persona client expenses are not allowable costs.

(3) Costs with are reimbursable under Medicaid programs other than rehabilitative services are unallowable costs for rehabilitative services, such as pharmacy and drug expenses, costs associated with medical laboratory services, residential expenses for room and board of clients, and medical transportation costs.

(4) Financial and compliance audits required by TDMHMR as a condition of the provider's contract with TDMHMR are allowable costs.

(g) Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR)

(1) Voucherable Costs. Any expenses directly reimbursable to the provider through a voucher payment system are unallowable costs. Any expenses in excess of the limit, or ceiling, for a voucher payment system are unallowable costs.

(2) Preferred items. Costs for preferred items which are billed to the recipient, responsible party, or the recipient's family are not allowable costs.

(3) Medical costs Expenses for medical services not provided to Medicaid clients are not allowable on the cost report. Allowable medical costs are delineated in §406.251(f) and §406.252(b). To be considered allowable, these costs must comply with the general definition of allowable costs as stated in §409.9 of this title (relating to General Principles of Allowable and Unallowable Costs).

(4) Minimum useful lives for domestic quality furnishings and equipment for residential use. In addition to the minimum useful lives specified in §409. 10(b)(7) of this title (relating to Specifications for Allowable and Unallowable Costs), the following minimum useful lives are assigned to domestic quality furnishings and equipment for residential use. The following minimum useful lives are applied to any single item valued at $1,000 or more and having a useful life of more than one year at the time of purchase.

(A) Domestic quality furnishings and equipment for residential use. If the provider can document that the furnishing or equipment purchased was of domestic (household, non-commercial) quality and used in a residential setting, the provider may depreciate the value of the furnishing or equipment using the useful life specified herein.

(i) Sofas, couches, and chairs-useful life of five years.

(ii) Beds and mattresses-useful life of five years.

(iii) Washing machines and clothes dryers-useful life of four years.

(iv) Carpet-useful life of four years.

(B) Previously-owned (used) domestic quality furnishings and equipment. If the provider can document that the furnishing or equipment listed in subparagraph (A) of this paragraph was previously-owned (used) and document the age of the item at the time of the provider's purchase, the estimated life of the used furnishing or equipment is the number of years remaining in the furnishing's or equipment's depreciable life. If the provider cannot document that the furnishing or equipment was previously-owned (used) or cannot document the age of the item at the time of the provider's purchase, the estimated life of the furnishing or equipment is the number of years specified in subparagraph (A) of this paragraph.

(5) Surrogate decision-making costs. Reasonable and necessary costs related to Surrogate Consent Committee are allowable costs.

(6) Expenses for pre-vocational training.

(A) Definitions. Pre-vocational training is defined as training which is part of the active treatment of the individual which may involve the instruction and practice of dexterity skills, social skills, punctuality, following direction, and attention to tasks. In contrast, vocational training is defined as any training that is included in the Individual Program Plan that assists individuals in preparing for, finding, and maintaining specific individual employment.

(B) Allowable pre-vocational training costs. When pre-vocational training services are provided jointly to a variety of individuals in such a way that they may be classified as pre-vocational training or active treatment for some individuals and as vocational training for others, the allowable portion of the expenses is the portion that qualifies as active treatment. The allowable portion must be determined on a pro rata resident-day-of-service basis. It includes the cost of buildings, utilities, supplies, and staff utilized in the provision of such services.

(7) Chaplaincy or pastoral services. Expenses for chaplaincy or pastoral services are allowable costs.

(8) Financial and compliance audits. Financial and compliance audits required by TDMHMR as a condition of the provider's contract with TDMHMR are an allowable cost.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 24, 1995.

TRD-9509266 Ann Utley
Chair, Texas MHMR Board
Texas Department of
Mental Health and
Mental Retardation

Earliest possible date of adoption: September 1, 1995

For further information, please call: (512) 206-4516

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## Subchapter I. Rehabilitative Services for Persons with Mental Illness

### • 25 TAC §§409.351-409.357

The Texas Department of Mental Health and Mental Retardation (TDMHMR) proposes amendments to §§409.351-409.357, concerning rehabilitative services for persons with mental illness.

The purpose of the amendments is to revise the reimbursement methodology to allow a more accurate determination of reimbursement for rehabilitative services

Don Green, chief financial officer, has determined that there are no significant fiscal implications to local government or small businesses as a result of administering the sections as proposed. The use of the mean instead of the median for ratesetting will optimize the use of general revenue dollars to increase the matching federal revenue by $3.4 million in fiscal year 1995, $12.3 million in fiscal year 1996, $12.6 million in fiscal year 1997, $13.1 million in fiscal year 1998, and $13.6 million in fiscal year 1999. There is no anticipated local economic impact.

Ernest McKenney, director, Medicaid Administration, has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be a more accurate determination of reimbursement for rehabilitative services for persons with mental illness. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the proposed sections.

Questions about the content of the proposal may be directed to Ernest McKenney at (512) 323-3261. Written comments on the proposal may be sent to Linda Logan, director, Policy Development, Texas Department of Mental Health and Mental Retardation, P.O. Box 12668, Austin, Texas 78711-2668, within 30 days of publication.

Copies of the proposal may be obtained by writing to the Texas Department of Mental Health and Mental Retardation, Office of Policy Development, P.O. Box 12668, Austin, Texas 78711-2668, or by calling (512) 206-4516.

A public hearing will be held at 1:00 p.m. on August 17, 1995, in the TDMHMR Central Office auditorium at 909 West 45th Street in Austin to accept oral and written testimony concerning the proposed amendments. If interpreters for the hearing impaired are required, please notify Laura Thomas at least 72 hours prior to the hearing by calling (512) 206-4516.

The amendments are proposed under the Texas Health and Safety Code, Title 7, §532.015, which provides the Texas Board of Mental Health and Mental Retardation with rulemaking powers; and under the provisions of Texas Civil Statutes, Article 4413(502) §16, which provide the Health and Human Services Commission with the authority to administer federal medical assistance funds

The amendments implement the Texas Human Resources Code, §22.002 and §§32.001-32.040 and Texas Civil Statutes, Article 4413(502).

*§409.351. Definitions.* The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

Department–The Texas Department of Mental Health and Mental Retardation **(TDMHMR)** [TXMHMR] or its designee

Professional–A qualified mental health professional includes.

(A)-(E) (No change.)

(F) For services provided to persons with alcohol and other drug abuse disorders, a qualified mental health professional also includes a **Licensed Chemical Dependency Counselor** [Certified Alcohol and Drug Abuse Counselor (CADAC)], as defined by the Texas **Commission on Alcohol and Drug Abuse** [Association of Alcohol and Drug Abuse Counselors].

(G) (No change.)

Texas Department of Mental Health and Mental Retardation **(TDMHMR)** [TXMHMR]–The Texas Department of Mental Health and Mental Retardation or its designee.

*§409.352. Eligible Individuals.* To be eligible for Medicaid reimbursement of rehabilitative services under this section, individuals, regardless of age, must.

(1)-(4) (No change.)

(5) have a plan of care, developed by a Medicaid enrolled provider, that specifies rehabilitative services as necessary to ameliorate the effects of the individual's mental illness(es); or require rehabilitative services on a limited basis as part of the development of an initial plan of care, or require rehabilitative services of an emergency nature that precede the development of a plan of care or depart from the existing plan of care in terms of need, scheduling, frequency, or duration. Services provided prior to or outside of the plan of care must be documented as quickly as possible in the service record and before billing for such services [The need for such care must be prescribed in the plan of care.]

*§409.353. Rehabilitative Services.*

(a) (No change.)

(b) Services must be provided by a physician (MD or DO) licensed to practice in Texas, or by a professional or paraprofessional staff trained in accordance with the TDMHMR Mental Health Community Services Standards. The physician must see each patient and prescribe or approve the plan of care. Reimbursable rehabilitative services for persons with mental illness(es) include.

(1) (No change.)

(2) Crisis resolution. This consists of direct contacts by mental health professionals or paraprofessionals to ameliorate a crisis situation involving acute psychiatric dysfunction that places an individual at risk of a more restrictive placement, including a 24-hour inpatient setting. Reimbursable contacts may occur by telephone or face-to-face with the eligible individual in crisis, his caretaker or family, or with other collateral such as medical professionals, police, and landlord. These services are available 24 hours **a day**, seven days a week. Crisis services may include: continuous and close supervision; medical, nursing, and psychiatric assessment; medication administration and monitoring; detoxification; counseling; and/or referral to community-based or inpatient services

(3)-(9) (No change.)

*§409.354. Service Limitations.*

(a) (No change.)

(b) Specifically, reimbursement will not be made for the following.

(1) Services that are an integral and inseparable part of another Medicaid service,

(2) Outreach activities that are designed to locate individuals who are **potentially** [potential] Medicaid eligible;

(3)-(4) (No change.)

*§409.355. Provider Participation Requirements.* To participate in the Texas Medical Assistance Program, a provider agency of rehabilitative services for persons with mental illnesses must:

(1)-(2) (No change.)

(3) sign a written provider agreement with the Texas Department of Mental Health and Mental Retardation **(TDMHMR)** [TXMHMR] or its designee. By signing the agreement, the provider of rehabilitative services for persons with mental illnesses agrees to comply with the terms of the agreement and all regulations, rules, handbooks, standards, and guidelines published by **TDMHMR** [TXMHMR] or its designee.

(4) bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by **TDMHMR** [TXMHMR] or its designee.

(5) (No change.)

(6) meet the following criteria:

(A) be a community-based agency provided for under **the Texas Health and Safety Code, §534.054** [Texas Civil Statues, Articles 5547-202 through 5547-204].

(B) have a service delivery system that provides **required** [core and essential] services as outlined in **the Texas Health and Safety Code, §534.053** [Texas Civil Statues, Article 5547.204] and defined by **TDMHMR or its designee** [TXMHMR] in the TDMHMR Mental Health Community Services Standards.

(C) meet the TDMHMR Mental Health Community Services Standards; and

(D) be in compliance with the Guidelines for Annual Financial and Compliance Audits of Community MHMR Centers and/or other state policies and procedures as determined by **the** state auditor and **the TDMHMR** [TXMHMR] Office of Internal Audit.

*§409.356 Rehabilitative Services Reimbursement Methodology.*

(a) General information

(1) The Texas Department of Mental Health and Mental Retardation **(TDMHMR)** [TXMHMR] **or its designee** will reimburse qualified providers for rehabilitative services provided to Medicaid eligible persons with mental illness.

(2) The Texas **Board of** Mental Health and Mental Retardation [Board] determines reimbursement [rates] in accordance with **§§409.1-409.7** [§409.1 and §409.2] of this title (relating to General Specifications; [and] Methodology; **Basic Objectives and Criteria for Desk Review of Cost Reports; Determination of Inflation Indices; Notification; Adjusting Rates When New Legislation, Regulations, or Economic Factors Affect Costs; and Reviews and Administrative Hearings) The reimbursement is** [These rates are] uniform, [and are] determined prospectively and at least annually. **Reimbursement** [Rates] may be determined more often than annually if the Texas **Board of** Mental Health and Mental Retardation [Board] determines it to be necessary.

(b) Basis for the **reimbursement** [rate] analysis

(1) For the **reimbursement** [rate] period, providers will be reimbursed on the projected expenses required to provide rehabilitative services.

(2) **TDMHMR or its designee** [TXMHMR] will collect several different kinds of data These include the number of rehabilitative services units of service in 15-minute increments that clients receive and the number of direct care server minutes, defined as direct server time by staff The cost data will include direct costs, programmatic indirect costs, and general and administrative overhead costs. These costs include salaries, benefits, and other costs.

(3) The reimbursement [rate] will be developed via **TDMHMR or its designee's** [TXMHMR] cost report data submitted by providers, consultation with service providers, and professionals experienced in rehabilitative services.

(c) Reporting of Costs.

(1) Cost reporting. Providers must submit information annually, unless otherwise specified, on cost report forms provided by **TDMHMR or its designee** [TXMHMR] or on facsimiles formatted according to **TDMHMR or its designee's** [TXMHMR] specifications, and that are preapproved by **TDMHMR or its designee** [TXMHMR]. From the data, **TDMHMR or its designee** [TXMHMR] will develop and implement cost based statewide, uniform **reimbursements** [reimbursement rates] for rehabilitative services Providers must complete the cost report forms according to the rules and specifications set forth in the methodology specified in this section.

(2) Reporting period and due date Provider agencies must prepare the cost report to reflect rehabilitative activities during the designated cost report reporting period. The cost reports must be submitted to **TDMHMR or its designee** [TXMHMR] no later than 90 days following the end of the designated reporting period unless otherwise specified by **TDMHMR or its designee** [TXMHMR].

(3) Extension of the due date. **TDMHMR or its designee** [TXMHMR] may grant extensions of due dates for good cause. A good cause is one that the provider agency could not reasonably be expected to control. Provider agencies must submit requests for extensions in writing to **TDMHMR or its designee** [TXMHMR] before the cost report due date. **TDMHMR or its designee** [Provider Reimbursement Department staff] respond to requests within ten workdays of receipt.

(4) Failure to file an acceptable cost report If a provider agency fails to file a cost report according to all applicable rules and instructions, **TDMHMR or its designee** [TXMHMR] may withhold all provider payments until the provider agency submits an acceptable cost report.

(5) Allocation method. If allocations of cost are necessary, provider agencies must use and be able to document reasonable methods of allocation. **TDMHMR or its designee** [TXMHMR] adjusts allocated costs if **TDMHMR or its designee** [TXMHMR] considers the allocation method to be unreasonable. The provider agency must retain workpapers supporting allocations, as specified in 40 TAC §69.202.

(6) Cost report certification. Provider agencies must certify the accuracy of cost reports submitted to **TDMHMR or its designee** [TXMHMR] in the format specified by **TDMHMR or its designee** [TXMHMR]. Provider agencies may be liable for civil and/or criminal penalties if they misrepresent or falsify information.

(7) Cost data supplements. **TDMHMR or its designee** [TXMHMR] may at times require additional financial and statistical information other than the information contained on the cost report.

(8) Review of cost reports. **TDMHMR or its designee** [TXMHMR] staff review each cost report to ensure that all financial and statistical information submitted conforms to all applicable rules and instructions. The review of the cost report includes a desk audit. **TDMHMR or its designee** [TXMHMR] reviews all cost reports according to the criteria specified in §409.3 of this title (relating to Basic Objectives and Criteria for Desk Review of Cost Reports). If a provider agency fails to complete the cost report according to instructions or rules, **TDMHMR or its designee** [TXMHMR] returns the cost report to the provider agency for proper completion. **TDMHMR or its designee** [TXMHMR] may require information other than that contained in the cost report to substantiate reported information.

(9) On-site audits. **TDMHMR or its designee** [TXMHMR] may perform on-site audits on all provider agencies that participate in the Medicaid program for rehabilitative services. **TDMHMR or its designee** [TXMHMR] determines the frequency and nature of audits but ensures

that they are not less than that required by federal regulations related to the administration of the program.

(10) Notification of exclusions and adjustments. **TDMHMR or its designee** [TXMHMR] notifies providers of exclusions and adjustments to reported expenses made during desk reviews and on-site audits of cost reports as specified in §409.5 of this title (relating to Notification).

(11) Access to records. Each contracted provider must allow access to any and all records necessary to verify cost report information submitted to **TDMHMR or its designee** [TXMHMR]. This requirement includes records pertaining to related party transactions and other business activities engaged in by the contracted provider. If a provider agency does not allow inspection of pertinent records within 30 days following written notice from **TDMHMR or its designee** [TXMHMR], a hold is placed on vendor payments until access to the records is allowed. If the provider agency continues to deny access to records, **TDMHMR or its designee** [TXMHMR] may cancel the provider agency's contract.

(12) Recordkeeping requirements. Provider agencies must maintain records according to the requirements specified in Title 40, TAC, §69.202. Provider agencies must ensure that records are accurate and sufficiently detailed to support the financial and statistical information contained in cost reports.

(13) Failure to maintain adequate records. If a provider agency fails to maintain adequate records to support the financial and statistical information reported in cost reports, **TDMHMR or its designee** [TXMHMR] allows 90 days for the provider to bring recordkeeping into compliance. If a provider agency fails to correct deficiencies within 90 days from the date of notification of the deficiency, **TDMHMR or its designee** [TXMHMR] may cancel the provider agency's contract for services.

(d) Reimbursement [rate] determination **TDMHMR or its designee** [TXMHMR] determines **reimbursement** [rates] in the following manner.

(1) (No change.)

(2) Data collection. **TDMHMR or its designee** [TXMHMR] collects several different kinds of data. These include the number of rehabilitative services units of service in 15-minute increments that clients receive (client time) and the number of direct care service minutes by staff (server minutes). The cost data will include direct costs, programmatic indirect costs, and general and administrative overhead costs. These costs include salaries, benefits, and other costs. Other costs include nonsalary related costs such as building and equipment maintenance, repair, depreciation, amortization, and insurance expenses; employee travel and training expenses; utilities; plus material and supply expenses.

(A) (No change.)

(B) The server minutes can be given by professionals and paraprofessionals. These include, but are not necessarily limited to physicians, psychologists, nurses, social workers, mental health technicians, counselors, therapists, and therapy associates. **TDMHMR or its designee** [TXMHMR] collects the wages, salaries, benefits, and other costs so that **reimbursement** [flat rates] can be determined.

(C) (No change.)

(D) Costs are aggregated into three salary tiers based on the percentage of direct servers' salaries in each tier. A percentage is calculated by dividing the individual tiers by the total of the three tiers. These percentages are used as allocation factors to subdivide total net allowable costs into cost pools based on salary tier. Then each of these pools is separately allocated to the various rehabilitative services based on the percentage of server minutes utilized within each service category and salary tier. The server minutes are identified by individual service and salary tiers. **TDMHMR or its designee** [TXMHMR] determines **the reimbursement** [a flat rate] for providing each individual service by summing the total costs in each salary tier and then dividing the total cost of each service by the total units of service in 15-minute increments.

(3) **Reimbursement** [Rate setting] methodology. **TDMHMR** [TXMHMR] determines the recommended reimbursement [rates] using the following method:

(A) (No change.)

(B) Projected and adjusted costs. Reported costs are projected and adjusted prior to **calculations for determining reimbursement** [their being arrayed]. **TDMHMR or its designee** [TXMHMR] uses reasonable methods for projecting costs from the historical reporting period to the prospective **reimbursement** [rate] period. The historical reporting period is the time period covered by the cost report. Cost projections adjust the allowed historical costs for significant changes in cost related conditions anticipated to occur between the historical cost period and the prospective **reimbursement** [rate] period. Significant conditions include, but are not necessarily limited to, wage and price inflation or deflation, changes in program utilization and occupancy, modification of federal or state regulations and statutes, and implementation of federal or state court orders and settlement agreements. **TDMHMR or its designee** [TXMHMR] determines reasonable and appropriate economic adjusters, as specified in §409.4 of this title (relating to Determination of Inflation Indices), to calculate the projected expenses. The Implicit Price Deflator for Personal Consumption Expenditures (IPD-PCE), which is based on data from the U.S. Department of Commerce, is the most general measure of inflation and is applied to most salaries, materials, supplies, and services when other specific inflators are not appropriate. The three payroll tax inflators, FICA (Social Security), FUTA/SUTA (federal and state unemployment) and WCI (Workers' Compensation) are based on data obtained from the Statistical Abstract of the United States, the Texas Employment Commission and the Texas Board of Insurance, respectively. For community based providers, wage inflation factors are based on wage and hour survey information submitted on cost reports or special surveys or the IPD-PCE, when wage and hour survey information is unavailable. For state operated providers, the inflation factor is based on wage increases approved by the Texas Legislature. **TDMHMR or its designee** [TXMHMR] adjusts **reimbursement** [rates] if new legislation, regulations, or economic factors affect costs, as specified in §409.6 of this title (relating to Adjusting Rates when New Legislation, Regulations, or Economic Factors Affect Costs).

(C) **Reimbursement** [Rate] determination. **For each type of rehabilitative service each provider's cost per unit of service is calculated. The mean provider cost per unit of service is calculated, and the statistical outliers (those providers whose unit costs exceed plus or minus (+/-) two standard deviations of the mean provider cost) are removed. After removal of the statistical outliers, the mean cost per unit of service is calculated. This mean cost per unit of service becomes the recommended reimbursement per unit of service as of May 20, 1995.** [Provider costs per unit of service by individual type of service are arrayed from low to high. Statistical outliers (those providers whose unit costs exceed plus or minus (+/-) two standard deviations of the mean) are removed. For each type of service, the median cost per unit of service is selected, and this selection becomes the recommended reimbursement rate per unit of service, as of March 24, 1994.]

[(D) Offset of federal funds. TXMHMR offsets the approved rates by the amount of federal revenue received during

the reporting period and inflated to the rate period in the following manner:

[(i) Approval rates offset. TXMHMR adjusts approved rates downward on an individual provider basis to reflect that particular provider's receipt of federal funds. Federal funds that are offset must meet the following conditions:

[(I) Funds are used to provide rehabilitative services to clients or to a class of clients.

[(II) Funds received are not client specific; that is, the funds received are not designated for provision of services to specifically named clients.

[(ii) Ineligible claims. Whenever funds are received to cover the cost of rehabilitative services to a specific client or class of clients, a claim for reimbursement cannot be made.

[(iii) Adjustment factor. The adjustment factor is calculated and applied as follows:

[(I) A factor is calculated that is the result of federal revenues divided by total revenues used to fund rehabilitative services for the reporting period.

[(II) The percentage calculated in subclause (I) of this clause is multiplied by the rate for each individual service.

[(III) The result by service in subclause (II) of this clause is subtracted from each individual service.]

**(D)**[(iv)] **Reimbursement** [Rate] setting authority. The Texas **Board** of Mental Health and Mental Retardation [Board] establishes the reimbursement [rate] in an open meeting after consideration of financial and statistical information and public testimony. The Board sets **reimbursements** [rates] that, in its opinion, are within budgetary constraints, adequate to reimburse the cost of operations for an economic and efficient provider, and justifiable given current economic conditions.

**(E)**[(v)] Reviews of cost report disallowances. A provider agency may request notification of the exclusions and adjustments to reported expenses. made during either desk reviews or on-site audits, according to §409.5 of this title (relating to Notification). Providers may request an informal review and, if necessary, an administrative hearing to dispute the action taken by **TDMHMR or its designee** [TXMHMR] under §409.7 of this title (relating to Reviews and Administrative Hearings).

(F) [(E)] Requirements for allowable costs. Allowable costs must be:

(i) Necessary and reasonable for the proper and efficient administration of rehabilitative services for which **TDMHMR or its designee** [TXMHMR] has contracted;

(ii) Authorized or not prohibited under state or local laws or regulations;

(iii) Consistent with any limitations or exclusions described in this section, federal or state laws, or other governing limitations as to types or amounts of cost items;

(iv) Consistent with policies, regulations, and procedures that apply to both rehabilitative services and other activities of the organization of which the contracted agency is a part;

(v) Treated consistently using generally accepted accounting principles appropriate to the circumstances;

(vi) Not allowable to or included as a cost of any other program in either the current or a prior period; and

(vii) Net of all applicable credits.

**(G)** [(F)] Reasonableness. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by an ordinarily prudent person in the conduct of competitive business. In determining the reasonableness of a given cost, **TDMHMR or its designee** [TXMHMR] considers the following:

(i) whether the cost is of a type generally recognized as ordinary and necessary for the provision of rehabilitative services or the performance under the contract;

(ii) the restraints or requirements imposed by generally accepted sound business practices, arm's length bargaining, federal and state laws and regulations, and contract terms and specifications; and

(iii) the action that a prudent person would take in the circumstances, considering his responsibilities to the public, the government, his employees, clients, shareholders, and/or members, and the fulfillment of the purpose for which the business was organized.

**(H)**[(G)] List of allowable costs. The following list of allowable costs is not comprehensive but rather serves as a general guide and serves to clarify certain key expense areas. The absence of a particular cost does not necessarily mean it is not an allowable cost. The following are allowable costs:

(i) Advertising expenses (employee recruitment, in the yellow pages and to meet regulatory requirements);

(ii) Automatic data processing equipment leasing expenses;

(iii) Bonding expenses;

(iv) Civil defense expenses;

(v) Compensation for personal services, including back pay;

(vi) Cost of money (interest);

(vii) Depreciation;

(viii) Economic planning (allowable only as an indirect cost);

(ix) Employee morale, health, welfare, food service and dormitory expenses and credit;

(x) Fringe benefits;

(xi) Insurance and indemnification;

(xii) Labor relations expenses;

(xiii) Maintenance and repair;

(xiv) Material and supply cost;

(xv) Patent expenses;

(xvi) Pension plans;

(xvii) Plant protection expenses;

(xviii) Recruitment expenses;

(xix) Relocation expenses;

(xx) Rental expenses;

(xxi) Service and warrant expense;

(xxii) Severance pay;

(xxiii) Special tooling and special test equipment expenses;

(xxiv) Termination expenses;

(xxv) Business, technical and professional activity expenses related to rehabilitative services;

(xxvi) Training and educational expenses;

(xxvii) Transportation expenses;

(xxviii) Travel expenses;

(xxix) Utilities;

(xxx) Utilization review committee.

(I)[(H)] Unallowable Costs. The following list of unallowable costs is not comprehensive, but rather serves as a general guide and clarifies certain key expense areas. The absence of a particular cost does not necessarily mean that it is an allowable cost. The following are unallowable costs:

(i) Alcoholic beverage expenses;

(ii) Bad debts and directly associated collection and legal costs;

(iii) Bid and proposal costs in excess of a set limit;

(iv) Board of directors fees;

(v) Congressional lobbying;

(vi) Contingency provisions as such;

(vii) Contributions and donations;

(viii) Entertainment expenses;

(ix) Executive lobbying costs;

(x) Fines and penalties for violations of regulations, statutes and ordinances of all types;

(xi) First class air travel unless authorized under specific circumstances and documented and justified;

(xii) Goodwill (acquired);

(xiii) Gains or losses on disposition of capital assets other than depreciable assets;

(xiv) Idle facility costs except in limited circumstances;

(xv) Independent research and development costs beyond set limits;

(xvi) Insurance, retroactive or backdated;

(xvii) Interest costs for operating funds;

(xviii) Legal fees defending fraud (and litigating appeals against the government);

(xix) Long term leases of property and equipment and leases from related parties are limited to the costs of ownership;

(xx) Losses on other contracts;

(xxi) Organization expenses;

(xxii) Product advertising;

(xxiii) Professional service costs to prosecute claims against the U.S.;

(xxiv) Promotional and fund raising expenses;

(xxv) Social club memberships;

(xxvi) Stock options and some forms of deferred compensation;

(xxvii) Trade discounts of all types (returns, allowances and refunds);

(xxviii) Certain taxes.

*§409.357. Right to Appeal.* **Applicants have the right to appeal TDMHMR or its designee's decisions according to §409.7 of this title (relating to Reviews and Administrative Hearings). Requests for hearings should be submitted to TDMHMR.** [Applicants for medical assistance and recipients have the right to appeal TDHS decisions according to TDHS's fair hearing rules contained in 40 TAC Chapter 79.]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 21, 1995.

TRD-9509313 Ann Utley
Chair, Texas MHMR Board
Texas Department of
Mental Health and
Mental Retardation

Earliest possible date of adoption: September 1, 1995

For further information, please call: (512) 206-4516

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# TITLE 31. NATURAL RESOURCES AND CONSERVATION

## Part II. Texas Parks and Wildlife Department

## Chapter 55. Law Enforcement

The Texas Parks and Wildlife Commission proposes the repeal of §§55. 143-55.153, an amendment to §55.142, and new §§55.143-55.153, concerning permits for aerial management of wildlife and exotic animals. Senate Bill 329, enacted by the 74th Legislature, consolidates the aerial management permit and the aerial depredation permit into a single permit. The repeals, amendment and new sections are necessary, therefore, in order for the department to conform its regulations to the new statutory provisions which take effect September 1, 1995. The repeals, amendment, and new rules will function by establishing the criteria and conditions under which the department may issue aerial management permits.

Robin Riechers, staff economist, has determined that for the first five-year period the sections are in effect there will be fiscal implications for state government as a result of enforcing or administering the sections as proposed; however, that impact cannot be quantified at this time. There are no anticipated fiscal implications for local government.

Mr. Riechers also has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be the appropriate management of wildlife resources from aircraft consistent with sound biological practices. The anticipated economic impact to small businesses and persons required to comply with the rules as proposed will be the cost of a permit.

Comments on the proposed repeals, amendment and new sections may be submitted to David Sinclair, Law Enforcement Division, Texas Parks and Wildlife Department, 4200 Smith School Road, Austin, Texas 78744, (512) 389-4854 or 1-800-792-1112, extension 4854.

### Subchapter E. Management of Wildlife and Exotic Animals From Aircraft [Depredating Animal Control and Wildlife Management From Aircraft]

- **31 TAC §§55.143-55.153**

*(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Parks and Wildlife Department or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)*

The repeals are proposed under the Parks and Wildlife Code, Chapter 43, Subchapter G, which authorizes the Commission to establish regulations governing the management of wildlife or exotic animals by aircraft.

The repeals implement Senate Bill 329, Acts of the 74th Texas Legislature, 1995.

*§55.143. Application for Permit.*

*§55.144. Landowner Authorization.*

*§55.145. Issuance of Permit.*

*§55.146. Period of Validity of Permit.*

*§55.147. Amendment of Permit.*

*§55.148. Renewal of Permit.*

*§55.149. Permit Not Transferable.*

*§55.150. Permit Fee.*

*§55.151. Reports.*

*§55.152. General Rules.*

*§55.153. Penalty.*

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 21, 1995.

TRD-9509257 Paul M. Shinkawa
Acting General Counsel
Texas Parks and Wildlife Department

Earliest possible date of adoption: September 1, 1995

For further information, please call: (512) 389-4642

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## • 31 TAC §§55.142-55.153

The amendment and new sections are proposed under the Parks and Wildlife Code, Chapter 43, Subchapter G, which authorizes the Commission to establish regulations governing the management of wildlife or exotic animals by aircraft.

The amendment and new sections implement Senate Bill 329, Acts of the 74th Texas Legislature, 1995.

*§55.142. Definitions.* The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

[Aerial Depredating Animal Permit-An authorization issued in the name of an individual or corporation for named person(s) to take, shoot at, or shoot from an aircraft a specific number of depredating animals during specified times, on certain lands described in the landowner's consent authorization.]

Aerial [Wildlife] Management Permit-**A permit issued by the department** [An authorization issued in the name of an individual or corporation for named pilot(s)] to count, photograph, relocate, [or] capture, **or hunt wildlife or exotic animals** by the use of aircraft[, wildlife during specific times and on certain lands described in the landowner's consent authorization].

Applicant-An individual, **partnership,** or corporation who files an application for a permit to [control depredating animals or] manage wildlife **or exotic animals** by use of aircraft.

**Convicted-Means a judgment of guilty, plea of guilty or nolo contendre, or placed on probation or deferred adjudication.**

Depredating animals-Feral hogs, bobcats, red fox, [exotic animals,] coyotes, and crossbreeds between coyotes and dogs.

[Director-Executive Director of Parks and Wildlife Department.]

Exotic animals-**Exotic livestock and exotic fowl as defined by Agriculture Code, §161.001(a)** [those animals listed in the Texas Parks and Wildlife Code, §62.015], and wild animals that are non-indigenous to Texas [listed in Parks and Wildlife Code, §12.601]. **This definition does not include aoudad sheep and elk in counties where they are listed as game animals under the provisions of Parks and Wildlife Code, Chapter 63, Subchapter A.**

Gunner-An individual who **uses a firearm, tranquilizer gun, or net gun to capture, take, shoot, or attempts to capture, take, or shoot wildlife or exotic** [takes, shoots, or shoots at depredating] animals from an aircraft.

Landowner's [consent] authorization-**Signed consent** [An authorization] from the landowner or the landowner's authorized agent to **manage** [hunt] a specified number of **wildlife or exotic animals** [depredating animals or to manage wildlife] from an aircraft on certain property.

**Management** [manage] by the use of [an] aircraft-**To manage wildlife or exotic animals by counting, photographing, relocating, capturing, or hunting** [to count, photograph, relocate, or capture wildlife] by the use of aircraft.

Observer-Any person other than the pilot or gunner who is on board an aircraft while **wildlife or exotic animals are being counted, photographed, relocated, captured, or hunted** [operating under the authority of an aerial depredating animal permit or an aerial wildlife management permit].

**Permit-An aerial management permit.**

Pilot-An individual [named in a permit] who pilots an aircraft to **count, photograph, relocate, capture, or hunt** [take, shoot, or shoot at depredating animals or to manage] wildlife **or exotic animals.**

Wildlife-Any vertebrate species **or their hybrids that normally live in a state of nature and are not ordinarily domesticated** [other than a domesticated animal]. **This definition includes depredating animals.**

*§55.143. General Rules.*

(a) A person who holds a permit under the authority of Parks and Wildlife Code, Chapter 43, Subchapter G, is authorized to engage in the management of wildlife and exotic animals by the use of aircraft only on land named in the landowner's authorization. The permit shall be carried in aircraft when performing management by the use of aircraft.

(b) A pilot of an aircraft used for the management of wildlife or exotic animals must maintain a daily flight log and report. The daily flight log must be current and available for inspection by game wardens at reasonable times. Each permit holder and pilot shall comply with all Federal Aviation Regulations for the specific type of aircraft listed on their permit.

(c) A person commits an offense if:

(1) the person hunts, shoots, shoots at, kills, or attempts to kill from an aircraft any wildlife or exotic animals other than wildlife or exotic animals authorized by the permit and landowner's authorization;

(2) the person intentionally disturbs, hazes, or buzzes any wildlife or exotic animals by the use of an aircraft other than wildlife or exotic animals authorized in a permit and landowner's authorization;

(3) the person acts as a gunner, observer, or pilot during a flight related to management of wildlife or exotic animals from an aircraft, and has within one year immediately preceding the flight been convicted of a Class A Parks and Wildlife Code misdemeanor or Parks and Wildlife Code felony relating to the management of wildlife or exotic animals by the use of aircraft;

(4) the person pilots an aircraft to manage wildlife or exotic animals without a valid pilot's license as required by the Federal Aviation Administration;

(5) the person pays, barters, or exchanges anything of value to participate as a gunner or observer;

(6) the person acting as a gunner or pilot under an aerial management permit takes or attempts to take any wildlife or exotic animals for any purpose other than is necessary for the protection of lands, water, wildlife, livestock, domesticated animals, human life, or crops, except that any wildlife or exotic animals, once lawfully taken pursuant to this subchapter may be sold if their sale is not otherwise prohibited;

(7) the person acting as a gunner or pilot hunts, takes, kills, manages or attempts to hunt, take, kill or manage wildlife or exotic animals during the hours between 1/2-hour after sunset and 1/2-hour before sunrise;

(8) the person operates an aircraft for the management of wildlife or exotic animals and is not named as an authorized pilot in a permit;

(9) the person takes, captures, or kills more wildlife or exotic animals on properties specified in the landowner's authorization than are specified in the landowner's authorization; or

(10) the person uses a permit for the purpose of sport hunting.

(d) These rules do not exempt any person from the requirement for other licenses or permits required by statute or proclamation.

*§55.144. Application for Permit.* An applicant for a permit shall complete and place on file an application on a form prescribed by the department. The application shall contain the description, including make, model, color, and registration number of each aircraft to be used. The name of each individual pilot will be shown exactly as it appears on their state driver's license, personal identification certificate issued by the Department of Public Safety, or the FAA license, along with a current address and date of birth of the applicant (date of birth not applicable if corporation), and the name, address, hunting license number, and date of birth of each pilot.

*§55.145. Issuance of Permit.*

(a) A permit may be issued in the name of an individual, partnership, or corporation for named pilots to count, photograph, relocate, capture, or hunt wildlife or exotic animals by the use of aircraft.

(b) Upon the filing of a properly executed application, the department may issue a permit if:

(1) the applicant, or any pilot named in the application, has not within one year immediately preceding the date of the application been convicted of any Class A Parks and Wildlife Code misdemeanor or Parks and Wildlife Code felony relating to the management of wildlife or exotic animals by the use of aircraft;

(2) the applicant has not knowingly failed to disclose any material information required, or has not knowingly made any false statement regarding any material fact in connection with the application;

(3) the applicant will use the permit only for the purpose of protecting or aiding in the administration or protection of land, water, wildlife, livestock, domesticated animals, human life, or crops;

(4) the permit requested, in the judgment of the issuing official, will aid in the management of wildlife and exotic animals and will not have a deleterious effect on indigenous species.

(c) The permit shall include the following information:

(1) the name and address of the individual applicant, partnership or corporation;

(2) the authorized pilot's name, address, date of birth, and Federal Aviation Administration Certificate number;

(3) the authorized aircraft; and

(4) the issue and expiration date of the permit.

*§55.146. Period of Validity of Permit.* A permit is valid for a period of one year from the date of issuance unless sooner terminated or revoked.

*§55.147. Amendment of Permit.*

(a) When a permittee desires to have his permit amended, he must file an amended application on the form provided by the department. An application for amendment is subject to the same issuance criteria as the original application for permit. In emergency situations, permit amendments and new landowner's authorizations may be expedited by presenting completed forms to the game warden in the county where the management of wildlife or exotic animals is to be performed.

(b) A game warden in the county where the land is located may approve the landowner's authorization and cause the form to be delivered to the department office in Austin. In such emergency situations, the landowner's authorization form will be considered on file when approved by the game warden.

(c) In situations involving only counting and photographing, the landowner's authorization for management of wildlife or exotic animals is considered on file when signed by both the permittee and landowner or landowner's agent and placed in the mail to the department office in Austin prior to flight.

*§55.148. Renewal of Permit.* A permittee requesting a renewal of a permit must file a properly executed application on a form prescribed by the department, together with the required fee, at least ten days prior to the expiration of the current permit.

*§55.149. Permit Not Transferable.* A permit is not transferable or assignable.

*§55.150. Permit Fee.* The annual fee for a permit to manage wildlife or exotic animals by the use of an aircraft is $200. The fee must accompany the application for the permit which is refundable should the permit application be denied. The department may exempt governmental entities from the permit fee.

*§55.151. Landowner Authorization.*

(a) Prior to managing wildlife or exotic animals, a permit holder must place on file a landowner's authorization form for each individual ownership on which wildlife or exotic animals are to be managed. The landowner's authorization form shall include:

(1) the name, address, and phone number of the landowner;

(2) the name, address, and phone number of the authorized landowner's agent, if applicable;

(3) the name and permit number of the permittee;

(4) the farm or ranch name and specific location of the property;

(5) the specific kind and number of wildlife or exotic animals to be managed by use of aircraft and the reason why these animals should be managed; and

(6) a trap and transplant permit number issued by the Department's Wildlife Division must be shown, if game animals or game birds are captured by the use of aircraft.

(b) A landowner's authorization for the management of wildlife or exotic animals shall be valid for one year unless the permit expires without renewal, is suspended or revoked. The landowner's authorization to manage wildlife or exotic animals is not valid until approved and placed on file.

(c) A landowner's authorization for hunting shall be approved only for depredating animals and exotic animals.

(d) A landowner's authorization will not be approved for non-indigenous wild animals except as authorized by the department when a specific wild animal(s) has escaped from captivity.

(e) a single landowners's authorization form may be submitted by a group of landowners or by an association on behalf of such landowners. The landowner's authorization form shall have attached a list of participating landowner names, ranch names, addresses, and acreage for each participating landowner. The landowner's authorization may be signed by one authorized agent who represents the group of landowners or an association.

*§55.152. Reports.*

(a) The holder of a permit shall file with the department within 30 days following the end of each calendar quarter or on termination of the permit, whichever occurs first, a daily flight log and report, on a form prescribed by the department, showing:

(1) name, signature, and permit number of the permit holder;

(2) number and description of the wildlife or exotic animals managed under the permit;

(3) the landowner's authorization control number issued by the department;

(4) the dates of authorized flights taken;

(5) the time of day an authorized flight is completed;

(6) type of management by use of aircraft performed;

(7) the name and signature of pilot(s); and

(8) the name, address, and hunting license number of the gunner(s).

(b) Information required on the daily flight log and report shall be entered daily immediately upon completion of an authorized flight. Stopping to refuel does not constitute completion of a flight.

(c) The holder of a permit shall be required to file with the department a negative daily flight log and report, if there are no management flights for the calendar quarter.

*§55.153. Penalty.* The penalties for violations of these rules are prescribed by the Parks and Wildlife Code, §43.111.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 21, 1995.

TRD-9509351 Paul M Shinkawa
Acting General Counsel
Texas Parks and Wildlife Department

Earliest possible date of adoption. September 1, 1995

For further information, please call: (512) 389-4642

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# Title 37. PUBLIC SAFETY AND CORRECTIONS

## Part VI. Texas Department of Criminal Justice

### Chapter 152. Institutional Division

### Subchapter A. Prison Admissions

### • 37 TAC §152.1

The Texas Department of Criminal Justice proposes new §152.1 concerning the scheduled admissions policy. The new section is a result of the repeal of the prison allocation formula and its replacement with the scheduled admissions policy, all in accordance with Texas Government Code, §499.071. Also, Texas Government Code, §499.121(c) requires acceptance of felons from county jails within 45 days of reaching "paper-ready" status; this new section is intended to meet that requirement.

David P. McNutt, Assistant Director for Budget and Management Services, has determined that there will be no fiscal implications for state and local governments as a result of enforcing or administering the rule.

Mr. McNutt also has determined that for each year of the first five years the rule as proposed is in effect the public benefit anticipated as a result of enforcing the section will be timely acceptance into state facilities of persons with felony convictions. There will be no effect on small businesses. There is no anticipated economic cost to persons required to comply with the rule as proposed.

Comments should be directed to Carl Reynolds, General Counsel, Texas Board of Criminal Justice, P.O. Box 13084, Austin, Texas 78711. Written comments from the general public should be received within 30 days of the publication of this proposal.

The new section is proposed under the Government Code, §492.013, which grants general rulemaking authority to the Board, §499.071 (as amended by the 74th Legislature, Regular Session), and §499.121(c), which requires the institutional division to accept inmates from county jails within 45 days of reaching paper-ready status.

The Government Code, §499.071 and §499.121(c) is affected by this proposed new rule.

*§152.1. Scheduled Admissions Policy.*

(a) Counties shall send commitment papers on inmates sentenced to TDCJ to the TDCJ Records Office immediately following completion of the commitment papers. Those counties equipped to do so may send paperwork electronically.

(b) The 45 days begins the date the commitment papers are sent. If sent by mail, the 45 days begins on the post-marked date.

(c) Inmates will be scheduled for admission based on:

(1) their length of confinement in relation to the 45 days from paper-ready status, and

(2) transportation routes.

(d) Counties shall inform the TDCJ Records Office when paper-ready inmates are transferred to another facility due to bench warrants.

(e) TDCJ will notify counties via electronic transmission (facsimile or computer transmission) when applicable, of inmates scheduled for intake, the date of intake, respective reception unit, and transportation arrangements. Inmates will be sorted by name and State Identification (SID) number, as identified by court docket.

(f) Counties shall in turn notify the TDCJ Intake Coordinator of any inmates who are not available for transfer and why.

(g) Special inmate categories (medical or security) may be scheduled for intake out of sequence on a case-by-case basis by contacting the TDCJ Intake Coordinator.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 24, 1995.

TRD-9509322 Carl Reynolds
General Counsel
Texas Department of Criminal Justice

Earliest possible date of adoption: September 1, 1995

For further information, please call: (512) 463-9693

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### Chapter 163. Community Justice Assistance Division Standards

### • 37 TAC §163.46

The Texas Department of Criminal Justice proposes new §163.46, concerning percentage change limits between fiscal years for the community Corrections Program allocation formula. This new section is permitted by Texas Code of Criminal Procedure, Article 42.13, §10. Assuming adequate appropriations, the proposed policy limits for all community supervision and corrections department the percentage of loss between fiscal years that may be realized as a result of the allocation formula. An upper change limit will be determined by available funding and the size and number of departments that reach the decrease limit. In the event that appropriations are inadequate to maintain the decrease limits, all department will be reduced the same percentage from their previous year's allocations

David P. McNutt, Assistant Director for Budget of the Department of Criminal Justice, has determined that the new section will have no effect on state government for the first five-year period of operations. The adoption of the section will impose no additional overall costs upon local government, but may impact specific community supervision and corrections departments by increasing or decreasing the amount of funding allocated to the department through the Community Corrections Program. The actual fiscal impact of this section will vary by department and fiscal year.

Mr. McNutt also has determined that the public benefit anticipated to the general public for the next five years will be to enhance the operations of community supervision and corrections departments by limiting funding changes between fiscal years. There will be no effect on small businesses. There is no anticipated economic costs to persons, as no individuals have a duty to comply.

Comments should be directed to Dimitria Pope, Director, Community Justice Assistance Division, P.O. Box 12427, Austin, Texas 78711. Written comments from the general public should be received within 30 days of the publication of this proposed section.

The new section is permitted by the Texas Code of Criminal Procedure, Article 42.13, §10, which gives the Board of Criminal Justice the authority to adopt a policy limiting for all departments the percentage of benefit or loss that may be realized as a result of the operation of the Community Corrections Program allocation formula

The Texas Code of Criminal Procedure, Article 42.13, §10 is affected by this proposed new rule

*§163.46 Allocation Formula for Community Corrections Program*

(a) Purpose. The Texas Code of Criminal Procedure, Article 42 13, §10, gives the Texas Board of Criminal Justice (TBCJ) discretion to adopt a policy limiting the percentage of benefit or loss that may be realized by a community supervision and corrections department (CSCD) as a result of the Community Corrections Program allocation formula

(b) Loss limits. Assuming adequate appropriations, no CSCD may incur a funding decrease of more than 5 0% from the previous fiscal year. An upper change limit shall be determined by available funding and the size and number of department that reach the decrease limit. If appropriations are inadequate to maintain the 5.0% decrease limit, all CSCD allocations will be reduced proportionately from the previous year's allocations.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt

Issued in Austin, Texas, on July 24, 1995

TRD-9509328 Carl Reynolds
General Counsel
Texas Department of Criminal Justice

Earliest possible date of adoption September 1, 1995

For further information, please call (512) 463-9693

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# TITLE 40, SOCIAL SERVICES AND ASSISTANCE

## Part I. Texas Department of Human Services

### Chapter 19. Long Term Care Nursing Facilities Requirements for Licensure and Medicaid Certification

The Texas Department of Human Services (DHS) proposes the repeal of §19. 1808 and §19 1809, amendments to §§19.1801-19 1807, concerning reimbursement methodology for nursing facilities, and proposes new §19.2701 and §19 2702, new Subchapter BB, concerning nursing facility program cost determination process, in its Nursing Facilities Requirements for Licensure and Medicaid Certification chapter. The purpose of the proposal is to establish cost determination rules that are consistent across programs, provide explicit guidelines for auditors, provide specific instructions concerning cost reporting, provide guidelines in areas such as documentation and allocation methods, clarify current reimbursement methodology practices, and incorporate cost report procedural changes. The proposal also discontinues voucher payments for oxygen costs incurred after December 31, 1994; for costs incurred after December 31, 1994, the allowable costs for oxygen will be part of the daily reimbursement rate. In addition, the proposal implements the use of a trimmed mean for the Recipient Care Cost Center (if a provider's cost exceeds three standard deviations) and specifies not annualizing partial-year cost reports.

These sections were proposed in the December 30, 1994, issue of the *Texas Register* and withdrawn on June 27, 1995. The current proposal includes the original proposal as revised in response to public comments received during that publication process.

Also in this issue of the *Texas Register*, DHS is proposing new Chapter 20 and related policies in Chapters 24, 46, 47, 48, 50, and 52 of this title.

Burton F. Raiford, commissioner, has determined that for the first five-year period the sections are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the sections

Mr Raiford also has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be a single set of guidelines to facilitate financial accountability relating to service delivery, a better understanding of the reimbursement methodology due to inclusion of additional detail, and simplification of the method of reimbursing facilities for the allowable costs of oxygen. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the proposed sections

A public hearing will be held at 3.00 p m on August 16, 1995, in the Texas Department of Mental Health and Mental Retardation Central Office auditorium at 909 West 45th Street in Austin

Questions about the content of this proposal may be directed to Pam McDonald at (512) 450-4086 in DHS's Rate Analysis Department Written comments on the proposal may be submitted to Nancy Murphy, Media and Policy Services-177, Texas Department of Human Services E-205, P O Box 149030, Austin, Texas 78714-9030, within 30 days of publication in the *Texas Register* Contact Kathy Hall in Austin at (512) 450-3702, or a local DHS office, for copies of the proposed rules

### Subchapter S. Reimbursement Methodology for Nursing Facilities

**• 40 TAC §§19.1801-19.1807**

The amendments and new sections are proposed under the Health and Safety Code, Chapter 242, which provides the department with the authority to regulate long-term care nursing facilities; the Human Resources Code, Title 2, Chapters 22 and 32, which authorizes the department to administer public and medical assistance programs; and under Texas Civil Statutes, Article 4413(502), §16, which provide the Health and Human Services Commission with the authority to administer federal medical assistance funds.

The amendments and new sections implement the Human Resources Code, §§22. 001-22 024 and §§32.001-32.040.

*§19.1801. General Reimbursement Information.*

**(a) General requirements. Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §20.101 of this title (relating to Introduction).**

(b)[(a)] Texas Medicaid long-term care. The Texas Department of Human Services (DHS) reimburses Texas Medicaid long-term care contracted providers for care provided to recipients in nursing facilities (NF). The Texas Board of Human Services determines reimbursement rates that are statewide and uniform by class of service as specified in this section and in §24.101 and §24.102 of this title (relating to General Specifications and Methodology).

(c)[(b)] Uniform rates. Reimbursement rates are uniform statewide with the possible exception of demonstration or pilot implementation projects involving experimental classes, as specified in §19.1807(c) of this title (relating to Rate Setting Methodology).

*§19.1802. Cost Reporting* ***Requirements [Procedures]: 1994 and 1995 Cost Reports.*** **Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §19.2702 of this title (relating to Cost Report Requirements: 1996 and Subsequent Cost Reports).** Each provider must submit financial and statistical information on cost report forms provided by the Texas Department of Human Services (DHS) or

on facsimiles which are formatted according to DHS specifications and are preapproved by DHS staff

(1)-(2) (No change)

(3) Recordkeeping requirements. Each provider must maintain records according to the requirements stated in §69.205 [§69 202] of this title (relating to Contractor's Records). Providers must ensure that records are accurate and sufficiently detailed to support the legal, financial, and other statistical information contained in the cost report. Failure to maintain records that support the information submitted on the cost report in a form which is in compliance with DHS's chart of accounts for long-term care providers constitutes an administrative contract violation. In the case of an administrative contract violation, penalties are applied as specified in §19.2609 [§19 2207] of this title (relating to **Vendor Hold** [Administrative Contract Violations])

(4)-(8) (No change)

(9) Failure to file an acceptable cost report Failure to file an acceptable cost report by the cost report due date constitutes an administrative contract violation. In the case of an administrative contract violation, penalties are applied as specified in §19.2609 [§19 2207] of this title (relating to **Vendor Hold** [Administrative Contract Violations])

(10) (No change)

(11) On-site cost report audits.

(A)-(B) (No change)

(C) Access to records. Each provider entity or its designated agent(s) must allow access to any and all records necessary to verify information submitted to DHS on Medicaid cost reports This requirement includes records pertaining to related-party transactions and other business activities engaged in by the provider Failure to allow inspection of pertinent records within 10 workdays following written notice from DHS constitutes an administrative contract violation. In the case of an administrative contract violation, penalties are applied as specified in §19.2609 [§19 2207] of this title (relating to **Vendor Hold** [Administrative Contract Violations]). If a central office or other entity pertaining to a multi-facility operation refuses access to records, then the penalties are extended to all related parties having Medicaid contracts with DHS Additional rules regarding access to records that are out-of-state may be found in Chapter 24 of the Human Resources Code

(D)-(E) (No change)

**(12) Cost reports for Medicaid-decertified facilities. If a provider has been Medicaid-decertified for more than 30 consecutive days during its fiscal year, a cost report must be prepared to reflect the activities of the provider for the portion of its fiscal year prior to decertification. The provider must submit this cost report to DHS no later than 90 calendar days following the provider's decertification date. If the provider is recertified, the provider must prepare a cost report to reflect the activities of the provider during the remainder of the provider's fiscal year following recertification.**

**(13) Providers excused from cost report submission. DHS may excuse providers from the requirement to submit a cost report. Requests to be excused from submitting a cost report must be received by DHS before the due date of the cost report. In instances when providers are excused from cost report submission, the payment to the provider is made in accordance with §19.1807 of this title (relating to Rate Setting Methodology).**

**(A) Providers are excused from cost report submission if the provider's Medicaid contract was in effect for 30 consecutive days or fewer during the provider's cost report fiscal year.**

**(B) DHS may excuse providers from the requirement to submit a cost report if DHS determines that circumstances beyond the control of the provider made cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by a governmental entity.**

**(C) Providers are excused from cost report submission if they provided services for less than 1,500 Medicaid patient days during the provider's cost report fiscal year.**

**(14) Final cost reports for change of ownership. Except when excused from the requirement to submit a cost report according to paragraph (13)(A), (B), or (C) of this subsection, when a facility changes ownership the prior owner must submit a completed cost report reflecting the facility's activities from the beginning of the prior owner's cost report fiscal year until the ownership-change effective date. The prior owner's vendor payments may be held until the department receives an acceptable final cost report according to §19.2308(2) of this title (relating to Change of Ownership).**

**(A) In cases where the prior owner's vendor payment is held, DHS will forward the final cost report to audit within seven calendar days of its receipt.**

**(B) In cases where the facility is sold and its prior year's cost report is pending audit completion, the owner's vendor payment may be held until the audit of the prior year's cost report and the final cost report are complete.**

**(15) Requirements for cost report completion. A completed nursing facility cost report must:**

**(A) have a property appraisal from a local taxing authority attached. DHS may excuse the provider from this requirement if the provider is exempt from ad valorem taxation and, in lieu of the property appraisal, attaches documentation from the local taxing authority certifying exemption from ad valorem taxation;**

**(B) not report figures for days of service and number of beds that reflect occupancy of greater than 100%;**

**(C) have a management contract attached, if applicable; and**

**(D) have a lease agreement attached, if applicable.**

*§19.1803. Allowable and Unallowable Costs[-General Information] : 1994 and 1995 Cost Reports.*

(a) General information. **Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §19.2701 of this title (relating to Allowable and Unallowable Costs: 1996 and Subsequent Cost Reports).** The Texas Department of Human Services (DHS) defines allowable and unallowable costs to identify expenses which are reasonable and necessary to provide recipient care to Medicaid recipients on the part of an economical and efficient provider. The primary objective of the cost reporting process is to determine fair and reasonable reimbursement rates to providers. To achieve that objective, DHS compiles a rate base consisting, if possible, only of allowable cost information. If DHS classifies a particular type of expense as unallowable for purposes of compiling a rate base, it does not mean that individual

providers may not make expenditures of this type. Allowable costs included in the rate base determine only the costs and maximum reimbursement rates associated with an economical and efficient operator. Cost reporting by DHS Medicaid contracted providers should be consistent with generally accepted accounting principles (GAAP). In cases where DHS cost reporting rules conflict with GAAP, IRS, or other authorities, DHS rules take precedence for Medicaid provider cost reporting purposes.

(b) (No change.)

*§19.1804. List of Allowable Costs.* **Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §19.2701 of this title (relating to Allowable and Unallowable Costs: 1996 and Subsequent Cost Reports).** The following list of allowable costs is not comprehensive, but serves as a general guide and clarifies certain key expense areas. The absence of a particular cost does not necessarily mean that it is not an allowable cost. Amounts, other than the Medicaid per diem rate, reimbursed to facilities for goods or services provided to Medicaid recipients by facility staff or consultants must be offset against the appropriate line items for salaries and wages or other service expenses in the recipient care cost center of the Medicaid cost report. Except where specific exceptions are noted, the allowability of all costs is subject to the general principles specified in §19.1803(a) of this title (relating to Allowable and Unallowable Costs: **1994 and 1995 Cost Reports**).

(1)-(12) (No change.)

*§19.1805. List of Unallowable Costs.* **Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §19.2701 of this title (relating to Allowable and Unallowable Costs: 1996 and Subsequent Cost Reports).** The following list of unallowable costs is not comprehensive, but rather serves as a general guide and clarifies certain key expense areas. The absence of a particular cost does not necessarily mean that it is an allowable cost. Except where specific exceptions are noted, the allowability of all costs is subject to the general principles specified in §19.1803(a) and (b) of this title (relating to Allowable and Unallowable Costs: **1994 and 1995 Cost Reports**):

(1)-(35) (No change.)

*§19.1806. Cost Finding Methodology*

(a) Exclusion of and adjustments to certain reported expenses. Providers are responsible for eliminating unallowable expenses from the cost report. The Texas Department of Human Services (DHS) reserves the right to exclude any unallowable costs from the cost report and to exclude entire cost reports from the **reimbursement determination database** [rate base] if there is reason to doubt the accuracy or allowability of a significant part of the information reported.

**(1) Cost reports included in the database used for reimbursement determination.**

**(A) Individual cost reports will not be included in the database used for reimbursement determination if:**

***(i)*** **the cost report represents costs accrued during a time period immediately preceding a period of decertification where the decertification was of a length greater than 30 calendar days;**

***(ii)*** **the cost report is a final cost report (due to a change of ownership or the facility no longer contracting to serve Medicaid clients) and one of the following applies:**

**(I) the final cost reporting period ended more than 30 days before the end of the facility's cost report fiscal year during the reporting period in question; or**

**(II) the final cost report was due before the department finalized the appropriate cost report form and hence the final cost report was completed on an inappropriate year's cost report form;**

***(iii)*** **the cost report represents costs accrued by a facility which provided less than 1,500 Medicaid days of service during its cost reporting period; or**

***(iv)*** **the cost reporting period is less than or equal to 30 calendar days in length.**

**(B) In addition to the reasons for excluding a cost report from the reimbursement determination database specified in subparagraph (A) of this paragraph, individual cost reports may not be included in the database used for reimbursement determination if:**

***(i)*** **there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported;**

***(ii)*** **there is reasonable doubt that a provider entity reflected economic and efficient operation, due to low utilization or operation for less than a full fiscal year; or**

***(iii)*** **an auditor determines that reported costs are not verifiable.**

**(C) In the event that a facility is controlled by different owners during a single calendar year and each owner submits a cost report with an ending date that falls within that calendar year and neither subparagraph (A) nor (B) of this paragraph preclude the use of either cost report, the cost report representing the most recent time period ending in the calendar year will be used in the reimbursement database.**

**(D) In the event that all cost reports submitted for a specific facility are disqualified through the application of subparagraph (A) and/or (B) of this paragraph, the facility will not be represented in the reimbursement database for the cost report year in question.**

[(1) DHS excludes from the rate base unallowable costs included on the cost report and makes adjustments to reported costs to ensure that the rate base reflects costs that:

[(A) are reasonable and necessary for the provision of recipient care;

[(B) represent economic and efficient use of resources; and

[(C) are consistent with federal and state Medicaid regulations.]

(2) Adjustments and exclusions of cost report data include, but are not necessarily limited to:

**(A) Revenue offsets.**

***(i)*** **For reimbursements calculated using 1993 cost report data, DHS offsets against reported expenses certain types of operating revenues, after reasonable allowances for overhead costs. Types of revenues offset against costs include payments for meals by employees or guests; income from rentals, barber and beauty shop operations, and vending machines; canteen and gift shop receipts; miscellaneous revenues; and Medicare Part B and private ancillary service revenues. Interest income is used to offset working capital interest expense, not to exceed total interest costs. An exception is interest income from funded depreciation accounts or qualified pension funds,**

which is not treated as a revenue offset item. For facilities reporting central office overhead expenses, interest income is offset against interest expenses before the allocation of central office costs to individual nursing facilities (NFs).

*(ii)* For reimbursements calculated using 1994 and 1995 cost report data, certain types of revenues such as income from operations not associated with providing contracted services are to be offset against the corresponding expenses prior to reporting the expenses on the cost report. Types of revenues to be offset against costs include payments for meals by employees or guests; income from rentals, barber and beauty shop operations, and vending machines; canteen and gift shop receipts; and miscellaneous revenues. Interest income is to be offset against working capital interest expense, not to exceed total interest costs. An exception is interest income from funded depreciation accounts or qualified pension funds, which is not to be treated as a revenue offset item. For facilities reporting central office overhead expenses, interest income is to be offset against interest expenses before the allocation of central office costs to individual NFs. Expenses incurred and revenue accrued for ancillary services provided to non-Medicaid residents are unallowable for Medicaid cost reporting purposes and are not to be reported on the cost report. It is the provider's responsibility to ensure that these non-Medicaid ancillary revenues and expenses are not included on the 1994 or 1995 Texas Medicaid Nursing Facility cost report.

*(iii)* Beginning with reimbursements calculated using the 1996 cost report data, providers must complete and submit cost reports in accordance with §§20.103(b)(15)(D) and 20.104 of this title (relating to Specifications for Allowable and Unallowable Costs, and Revenues).

[(A) Revenue offsets. DHS offsets against reported expenses certain types of operating revenues, after reasonable allowances for overhead costs. Types of revenues offset against costs include income from beauty and barber shop operations, prior year overpayments, vending machine proceeds, gift shop receipts, and payment for meals by employees or guests. Interest income is used to offset working capital interest expense, not to exceed total interest costs. An exception is interest income from funded depreciation accounts or qualified pension funds, which is not treated as a revenue offset item. For facilities reporting central office overhead expenses, interest income is offset against interest expenses before the allocation of central office costs to individual NFs.]

(B) Fixed capital asset costs.

*(i)* DHS staff determine fixed capital asset costs as detailed in this section.

*(ii)* Fixed capital asset costs are reimbursed in the form of a use fee calculated as described in §19.1807 of this title (relating to Rate Setting Methodology). The following fixed capital charges are excluded from the reimbursement base:

(I) building and building equipment depreciation and lease expense;

(II) mortgage interest;

(III) land improvement depreciation; and

(IV) leasehold improvement amortization.

[(B) Fixed capital asset costs. Effective September 1, 1990, fixed capital asset costs are reimbursed in the form of a use fee calculated as described under §19.1807(b)(1) of this title (relating to Rate Setting Methodology). Consequently, the following fixed capital charges are excluded from the rate base for purposes of calculating the general, administration, and dietary cost component; building and building equipment depreciation and lease expense; mortgage interest; land improvement depreciation; and leasehold improvement amortization. This exclusion does not apply to rates for facilities in the pediatric care reimbursement class described under §19. 1807(c)(2) of this title (relating to Rate Setting Methodology). Rates for the pediatric care class are based on allowable charges for fixed capital assets rather than the use fee formula specified under §19.1807(b)(1) of this title (relating to Rate Setting Methodology).]

(C)-(D) (No change.)

(E) Cost projections. For cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995, [As specified in §24. 301 of this title (relating to Determination of Inflation Indices)] DHS projects certain expenses in the rate base to normalize or standardize the reporting period and to account for cost inflation between reporting periods and the period to which the prospective rate applies as specified in §24.301 of this title (relating to Determination of Inflation Indices). For cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years, DHS projects certain expenses in the rate base to normalize or standardize the reporting period and to account for cost inflation between reporting periods and the period to which the prospective rate applies as specified in §20.108 of this title (relating to Determination of Inflation Indices).

(F) Costs exceeding three standard deviations. Allowable costs are divided by the applicable days of service for the reporting period and then totalled by cost center to determine the per diem cost. For the Recipient Care Cost Center, DHS staff rank from low to high all providers' projected per diem costs. Any contracted provider's projected per diem cost which exceeds three standard deviations distance from the mean projected per diem cost will be replaced by the nearest projected per diem cost within three standard deviations of the mean projected per diem cost.

(G) Annualizing partial year cost reports. When cost reports covering less than a full fiscal year of operation are used in reimbursement determination, costs and other data are not annualized for purposes of determining per diem costs and reimbursement.

(3) Notification of the public. When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from reimbursement determination for the reasons stated in paragraph (1)(B)(i) and (ii) of this subsection.

(b) (No change.)

(c) Reimbursement determinations and allowable costs. Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursement. DHS excludes from reimbursement determinations any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers.

(d) General information. In addition to the requirements of this section, cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §20. 104 of this title (relating to Revenues), §20.106 of this title (relating to Basic Objectives and

**Criteria for Audit and Desk Review of Cost Reports), and §20.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).**

*§19.1807. Rate Setting Methodology.*

(a) (No change.)

(b) Rate determination. **For reimbursements calculated using cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995, the** [The] Texas Board of Human Services determines general reimbursement rates for medical assistance programs for Medicaid recipients under provisions of the Human Resources Code, Chapter 24 (relating to Reimbursement Methodology). **For reimbursements calculated using cost reports pertaining to providers' fiscal years ending in 1996 and subsequent years, the Texas Board of Human Services determines general reimbursement rates for medical assistance programs for Medicaid recipients under provisions of Chapter 20 of this title (relating to Cost Determination Process).** The Texas Board of Human Services determines reimbursement rates for nursing facilities based on consideration of Texas Department of Human Services (DHS) staff recommendations. To develop reimbursement rate recommendations for nursing facilities, DHS staff apply the following procedures.

(1)-(5) (No change.)

(c)-(d) (No change.)

(e) Oxygen costs. **Oxygeiosts incurred on or after January 1, 1995, will not be reimbursed on cost reimbursement vouchers. Those oxygen costs must be reported as expenses on the cost report.**

[(1) DHS reimburses nursing facilities for the actual costs of oxygen. Payments are based on cost reimbursement vouchers that are to be submitted quarterly. Allowable costs are limited to expenses incurred for:

[(A) actual oxygen expenses up to a set amount determined by DHS, and

[(B) liquid oxygen, oxygen concentrators, and tank refills (oxygen only)

[(2) Durable medical equipment, including, but not limited to, tanks, concentrators, tubing, masks, valves, and regulators are included in the per diem (see §19.1701(b)(5)(A)(ii) of this title (relating to Vendor Payment (Items and Services Included)) for an explanation of covered durable medical equipment).

[(3) The facility must accept payment by DHS as payment in full for services, and neither the oxygen provider nor the facility may charge the recipient, his family, or his trust fund an additional fee.

[(4) Claims for services must be received by the 95th day from the last day of the preceding billing quarter assigned to the facility.

[(A) Rejected or adjusted claims may be resubmitted. These claims must be received by the 180th day from the date of the claim rejection.

[(B) Corrected claims must be received by the 180th day from the date of the paid claim.]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 24, 1995.

TRD-9509231 Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

Earliest possible date of adoption: September 1, 1995

For further information, please call: (512) 450-3765

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## • 40 TAC §19.1808, §19.1809

*(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Department of Human Services or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)*

The repeals are proposed under the Health and Safety Code, Chapter 242, which provides the department with the authority to regulate long-term care nursing facilities; the Human Resources Code, Title 2, Chapters 22 and 32, which authorizes the department to administer public and medical assistance programs; and under Texas Civil Statutes, Article 4413(502), §16, which provide the Health and Human Services Commission with the authority to administer federal medical assistance funds.

The repeals implement the Human Resources Code, §§22.001-22.024 and §§32.001-32.040.

*§19.1808. Chart of Accounts.*

*§19.1809. Medicare Part A Skilled Nursing Facility Deductible and Coinsurance Payment.*

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

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TRD-9509230 Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

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For further information, please call: (512) 450-3765

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# Subchapter BB. Nursing Facilities Program Cost Determination Process

## • 40 TAC §19.2701, §19.2702

The new sections are proposed under the Health and Safety Code, Chapter 242, which provides the department with the authority to regulate long-term care nursing facilities; the Human Resources Code, Title 2, Chapters 22 and 32, which authorizes the department to administer public and medical assistance programs; and under Texas Civil Statutes, Article 4413(502), §16, which provide the Health and Human Services Commission with the authority to administer federal medical assistance funds.

The new sections implement the Human Resources Code, §§22.001-22.024 and §§32.001-32.040.

*§19.2701. Allowable and Unallowable Costs: 1996 and Subsequent Cost Reports.*

(a) For the completion and submittal of cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years, providers must apply the information detailed in this section.

(b) The Nursing Facility (NF) program follows the general principles set forth in §20.101 of this title (relating to Introduction). The NF program follows the requirements of allowable and unallowable costs in §20. 102 and §20.103 of this title (relating to General Principles of Allowable and Unallowable Costs, and Specifications for Allowable and Unallowable Costs). The NF program follows the procedures for notification of exclusions and adjustments in §20.107 of this title (relating to Notification of Exclusions and Adjustments). The NF program follows the procedures for informal reviews and appeals set forth in §20.110 of this title (relating to Informal Reviews and Formal Appeals).

(c) In addition to the requirements of §20.102 and §20.103 of this title (relating to General Principles of Allowable and Unallowable Costs, and Specifications for Allowable and Unallowable Costs), the following apply to costs for the NF program.

(1) Medical costs. The costs for medical services and items delineated in

§19.2601 of this title (relating to Vendor Payment) are allowable. These costs must also comply with the general definition of allowable costs as stated in §20.102 of this title (General Principles of Allowable and Unallowable Costs).

(2) Chaplaincy or pastoral services. Expenses for chaplaincy or pastoral services are allowable costs.

(3) Voucherable costs. For all voucher payment systems except the voucher payment system for supplemental reimbursement for ventilator-dependent residents, any expenses directly reimbursable to the provider through a voucher payment system are unallowable costs. For all voucher payment systems except the voucher payment system for supplemental reimbursement for ventilator-dependent residents, any expenses in excess of the limit, or ceiling, for a voucher payment system are unallowable costs.

(4) Preferred items. Costs for preferred items which are billed to the recipient, responsible party, or the recipient's family are not allowable costs.

(5) Preadmission Screening and Annual Resident Review (PASARR) expenses. Any expenses related to the direct delivery of specialized services and treatment required by PASARR for residents are unallowable costs. These costs are reimbursed through the Texas Department of Mental Health and Mental Retardation or the Texas Department of Human Services Goal-Directed Therapy Program.

(6) Advanced Clinical Practitioner (ACP) or Licensed Professional Counselor (LPC) services. Expenses for services provided by an ACP or LPC are unallowable costs.

*§19.2702. Cost Report Requirements: 1996 and Subsequent Cost Reports.*

(a) For the completion and submittal of cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years, providers must apply the information detailed in this section.

(b) General information. Except where specific exceptions are noted herein, the Nursing Facility program follows the cost report requirements in §20.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(c) Cost reports for Medicaid-decertified facilities. If a provider has been Medicaid-decertified for more than 30 consecutive days during its fiscal year, a cost report must be prepared to reflect the activities of the provider for the portion of its fiscal year prior to decertification. The provider must submit this cost report to the Texas Department of Human Services (DHS) no later than 90 calendar days following the provider's decertification date. If the provider is recertified, the provider must prepare a cost report to reflect the activities of the provider during the remainder of the provider's fiscal year following recertification. The cost report pertaining to the fiscal year subsequent to recertification must be submitted to DHS according to §20.105(c) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(d) Providers excused from cost report submission. DHS may excuse providers from the requirement to submit a cost report. Requests to be excused from submitting a cost report must be received by DHS before the due date of the cost report. In instances when providers are excused from cost report submission, the payment to the provider is made in accordance with §19.1807 of this title (relating to Rate Setting Methodology).

(1) Providers are excused from cost report submission if the provider's Medicaid contract was in effect for 30 consecutive days or fewer during the provider's cost report fiscal year.

(2) DHS may excuse providers from the requirement to submit a cost report if DHS determines that circumstances beyond the control of the provider made cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by a governmental entity.

(3) Providers are excused from cost report submission if they provided services for less than 1,500 Medicaid patient days during the provider's cost report fiscal year.

(e) Final cost reports for change of ownership. Except when excused from the requirement to submit a cost report according to subsections (d)(1), (2), or (3) of this section, when a facility changes ownership the prior owner must submit a completed cost report reflecting the facility's activities from the beginning of the prior owner's cost report fiscal year until the ownership-change effective date. The prior owner's vendor payments may be held until the department receives an acceptable final cost report according to §19.2308(2) of this title (relating to Change of Ownership).

(1) In cases where the prior owner's vendor payment is held, DHS will forward the final cost report to audit within seven calendar days of its receipt.

(2) In cases where the facility is sold and its prior year's cost report is pending audit completion, the owner's vendor payment may be held until the audit of the prior year's cost report and the final cost report are complete.

(f) Requirements for cost report completion. A completed nursing facility cost report must:

(1) meet the definition of completed cost report specified in §20.105(b)(4)(A) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures)

(2) have a property appraisal from a local taxing authority attached. DHS may excuse the provider from the requirement to submit a property appraisal from a local taxing authority if the provider is exempt from ad valorem taxation and, in lieu of the property appraisal, attaches documentation from the local taxing authority certifying exemption from ad valorem taxation;

(3) not report figures for days of service and number of beds that reflect occupancy of greater than 100%;

(4) have a management contract attached, if applicable; and

(5) have a lease agreement attached, if applicable.

**This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.**

**Issued in Austin, Texas, on July 24, 1995.**

TRD-9509232

Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

**Earliest possible date of adoption: September 1, 1995**

**For further information, please call: (512) 450-3765**

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## Chapter 20. Cost Determination Process

### • 40 TAC §§20.101-20.111

**The Texas Department of Human Services (DHS) proposes new §§20.101-20. 111, in its new chapter, Cost Determination Process. The purpose of the new sections is to establish cost determination rules that are consistent across programs, provide explicit guidelines for auditors, provide specific instructions concerning cost reporting, and provide guidelines in areas such as documentation and allocation methods. Also in this issue of the *Texas Register*, DHS is proposing related policies in Chapter 19, Nursing Facility Requirements for Licensure and Medicaid Certification; Chapter 24, Reimbursement Methodology; Chapter 46, Residential Care; Chapter 47, Primary Home Care; Chapter 48, Community Care for Aged and Disabled, which includes client-managed attendant services, shared attendant care services, congregate and home-delivered**

meals, the nursing facility waiver program, community living assistance and support services, and the Medically Dependent Children Program; Chapter 50, Day Activity and Health Services; and Chapter 52, Emergency Response Services, all concerning reimbursement methodology.

These sections were proposed in the December 30, 1994, issue of the *Texas Register* and withdrawn on June 27, 1995. The current proposal includes the original proposal as revised in response to public comments received during that publication process.

Burton F. Raiford, commissioner, has determined that for the first five-year period the sections are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the sections.

Mr. Raiford also has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be a single set of guidelines to facilitate financial accountability relating to service delivery. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the proposed sections.

A public hearing will be held at 3:00 p.m. on August 16, 1995, in the Texas Department of Mental Health and Mental Retardation Central Office auditorium at 909 West 45th Street in Austin.

Questions about the content of this proposal may be directed to Carolyn Pratt at (512) 450-4057 in DHS's Rate Analysis Department. Written comments on the proposal may be submitted to Nancy Murphy, Media and Policy Services-177, Texas Department of Human Services E-205, P.O. Box 149030, Austin, Texas 78714-9030, within 30 days of publication in the *Texas Register*. Contact Kathy Hall in Austin at (512) 450-3702, or a local DHS office, for copies of the proposed rules.

The new sections are proposed under the Human Resources Code, Title 2, Chapters 22 and 32, which authorizes the department to administer public and medical assistance programs; and under Texas Civil Statutes, Article 4413(502), §16, which provide the Health and Human Services Commission with the authority to administer federal medical assistance funds.

The new sections implement the Human Resources Code, §§22.001-22.024 and §§32.001-32.042.

*§20.101. Introduction.*

(a) The information in this chapter applies to cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years.

(b) The Texas Department of Human Services (DHS) reimburses contracted providers for contracted client care according to the reimbursement methodologies for each program. Non-Medicaid, statewide, uniform reimbursements and reimbursement ceilings are approved by the Texas Board of Human Services (board). The board recommends for approval to the Texas Health and Human Services Commission (HHSC) medical assistance or Medicaid reimbursements that are uniform by class. In Medicaid programs where reimbursements are contractor-specific, the board recommends for approval to the HHSC the reimbursement parameter dollar amounts, e.g., ceilings, floors, or program reimbursement formula limits. Medicaid reimbursement methodology rules are developed and recommended for approval by the board to the HHSC. The HHSC has oversight authority with respect to the state's Medicaid rules. Whenever the terms "Texas Department of Human Services" or "DHS" occur, they each mean the Texas Department of Human Services or its designee.

(1) Objective of cost determination process. The objective of the cost determination process is to define direct and indirect costs which are allowable and, therefore, may be considered for use in the overall reimbursement determination process. The cost determination process seeks to collect accurate financial and other statistical data which constitute the foundation upon which reimbursements are determined.

(A) Cost-reporting. In order to ensure adequate financial and statistical information upon which to base reimbursement, DHS requires that each contracted provider submit a periodic cost report or supplemental report. It is the responsibility of the provider to submit accurate and complete information, in accordance with all pertinent DHS cost reporting rules and cost report instructions, on the cost report and any supplemental reports required by DHS.

(B) Pro forma costing. When historical costs are unavailable, such as in the case of a new program, reimbursement may be based on a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and estimating the basic types and costs of products and services necessary to deliver services meeting federal and state requirements.

(2) Relationship between cost determination and reimbursement determination processes. The cost determination process seeks to evaluate individual cost items of providers to determine their allowability and to determine whether individual cost reports are of reasonable accuracy for potential use in reimbursement determination. The reimbursement determination process takes the evaluation of allowable costs one step further by comparing allowable costs across providers to identify those levels of cost, either for individual cost items or groups of cost items, which must be incurred by efficient and economic providers of services meeting all state and federal standards. Thus, all costs allowed in the cost determination process may not necessarily be used in the reimbursement determination process. The basic objective of the reimbursement methodologies employed by DHS is to facilitate and balance the broader objectives of the programs administered by the agency by:

(A) promoting reasonable access for eligible clients to services that meet federal and state quality standards via contracting with an adequate number of qualified providers; and

(B) expending taxpayer dollars in a reasonable and prudent manner such that eligible clients are served at the lowest cost to taxpayers consistent with state and federal laws, standards and regulations, and with program objectives.

*§20.102. General Principles of Allowable and Unallowable Costs.*

(a) Allowable and unallowable costs. Allowable and unallowable costs, both direct and indirect, are defined to identify expenses which are reasonable and necessary to provide contracted client care and are consistent with federal and state laws and regulations. When a particular type of expense is classified as unallowable, the classification means only that the expense will not be included in the database for reimbursement determination purposes because the expense is not considered reasonable and/or necessary. The classification does not mean that individual contracted providers may not make the expenditure. The description of allowable and unallowable costs is designed to be a general guide and to clarify certain key expense areas. This description is not comprehensive, and the failure to identify a particular cost does not necessarily mean that the cost is an allowable or unallowable cost

(b) Cost-reporting process. The primary objective of the cost-reporting process is to provide a basis for determining appropriate reimbursement to contracted providers. To achieve this objective, the reimbursement determination process uses allowable cost information reported on cost reports or other surveys. The cost report collects actual allowable costs and other financial and statistical information, as required. Costs may not be imputed and reported on the cost report when no costs were actually incurred (except as stated in §20.103(b)(16)(A)(i) of this title (relating to Specifications for Allowable and Unallowable Costs) or when documentation does not exist for costs even if they were actually incurred during the reporting period.

(c) Accurate cost reporting. 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 accordance with allowable and unallowable cost guidelines in this section and in §20.103 of this title (relating to Specifications for Allowable and Unallowable Costs), revenue reporting guidelines in §20.104 of this title (relating to Revenues), cost report instructions, and applicable program rules. Reporting all allowable costs on the cost report is the responsibility of the contracted provider. The Texas Department of Human Services (DHS) is not responsible for the contracted provider's failure to report allowable costs; however, in an effort to collect reliable, accurate, and verifiable financial and statistical data, DHS is responsible for providing cost report training, general and/or specific cost report instructions, and technical assistance to providers. Furthermore, if unreported and/or understated allowable costs are discovered during the course of an audit desk review or field audit, those allowable costs will be included on the cost report or brought to the attention of the provider to correct by submitting an amended cost report.

(d) Cost report training DHS is responsible for conducting, at no charge to the provider, comprehensive cost report training for each contracted program. Beginning with the 1996 cost reports, it is the responsibility of the provider to ensure that each preparer signing the Cost Report Methodology Certification has attended cost report training conducted by DHS. Preparers may be employees of the provider or persons who have been contracted by the provider for the purpose of cost report preparation. Preparers must attend cost report training for each program for which a cost report is submitted. Preparers must attend cost report training for two consecutive years, after which they are required to attend training on at least a biannual basis. A copy of the most recent cost report training certificate for each preparer of the cost report must be submitted with each cost report. Failure to file a completed cost report signed by preparers who have attended the required cost report training constitutes an administrative contract violation. Refer to §20.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures) and §20.111 of this title (relating to Administrative Contract Violations). Travel costs to attend the state-sponsored cost report training are allowable within the travel limits specified in §20.103(b)(12) of this title (relating to Specifications for Allowable and Unallowable Costs). Contracted preparer's fees to attend state-sponsored cost report training are allowable.

(e) Generally accepted accounting principles. Except as otherwise specified by the cost determination process rules of this chapter, cost report instructions, or policy clarifications, cost reports should be prepared consistent with generally accepted accounting principles (GAAP), which are those principles approved by the American Institute of Certified Public Accountants (AICPA). Internal Revenue Service (IRS) laws and regulations do not necessarily apply in the preparation of the cost report. In cases where cost reporting rules differ from GAAP, IRS, or other authorities, DHS rules take precedence for provider cost-reporting purposes.

(f) Allowable costs. Allowable costs are expenses, both direct and indirect, that are reasonable and necessary, as defined in paragraphs (1) and (2) of this subsection, and which meet the requirements as specified in subsections (i), (j), and (k) of this section, in the normal conduct of operations to provide contracted client services meeting all pertinent state and federal requirements. Only allowable costs are included in the reimbursement determination process.

(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:

(A) 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

(B) 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.

(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:

(A) the expenditure was not for personal or other activities not directly or indirectly related to the provision of contracted services;

(B) the cost does not appear as a specific unallowable cost in §20. 103 of this title (relating to Specifications for Allowable and Unallowable Costs);

(C) 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;

(D) 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;

(E) 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;

(F) the costs are net of all applicable credits;

(G) allocated costs of each program are adequately substantiated; and

(H) the costs are not prohibited under other pertinent federal, state, or local laws or regulations.

(3) Direct costs are those costs which are incurred by a provider which 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.

(4) Indirect costs are those shared costs which benefit, or contribute to, the operation of providing contracted services, other business components, or the overall entity with which DHS has contracted. These costs could include, but are

not limited to, administration salaries and nonlabor costs, building costs, insurance expense, and interest expense Central office and/or home office administrative expenses are considered indirect costs. Indirect costs must be allocated, directly or as a pool of costs, across those business components sharing in the benefits of those costs

(g) Unallowable costs. Unallowable costs are expenses that are not reasonable or necessary, according to the criteria specified in subsection (f) (1)-(2) of this section and which do not meet the requirements as specified in subsections (i), (j), and (k) of this section or which are specifically enumerated in §20.103 of this title (relating to Specifications for Allowable and Unallowable Costs) or program-specific reimbursement methodology. Placement as an allowable cost on a cost report of a cost which has been determined to be unallowable may constitute an administrative contract violation and may constitute fraud. (Refer to §79.2103 of this title (relating to Statutory Bases) for the statutory basis for Medicaid fraud and §20.106(a) of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports)). In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §19.2609 of this title (relating to Vendor Hold) for nursing facilities or §20.111 of this title (relating to Administrative Contract Violations) for all other programs.

(h) Other financial and statistical data. The primary purpose of the cost report is to collect allowable costs to be used as a basis for reimbursement determination. In addition, providers may be required on cost reports to provide information in addition to allowable costs to support allowable costs, such as wage surveys, workers' compensation surveys, or other statistical and financial information. Additional data requested may include, when specified and in the appropriate section or line number specified, costs incurred by the provider which are unallowable costs All information, including other financial and statistical data, shown on a cost report is subject to the documentation and verification procedures required for an audit desk review and/or field audit. Inaccuracy in providing, or failure to provide, this information may constitute an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §19.2609 of this title (relating to Vendor Hold) for nursing facilities or §20.111 of this title (relating to Administrative Contract Violations) for all other programs.

(i) Related party transactions.

(1) In determining whether a contracted provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. Related to a contracted provider means that the contracted provider to a significant extent is associated or affiliated with, has control of, or is controlled by the organization furnishing the services, equipment, facilities, or supplies. Common ownership exists if an individual or individuals possess any ownership or equity in the contracted provider and the institution or organization serving the contracted provider. 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. If the elements of common ownership or control are not present in both organizations, then the organizations are deemed not to be related to each other. The existence of an immediate family relationship will create an irrebuttable 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, sister-in-law, brother-in-law, son-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

(I) first cousins

(2) A determination as to whether an individual (or individuals) or organization possesses ownership or equity in the contracted provider organization and the supplying organization, so as to consider the organizations related by common ownership, will be made on the basis of the facts and circumstances in each case. This rule applies whether the contracted provider organization or supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or nonprofit. In the case of a nonprofit organization, ownership or equity interest will be determined by reference to the interest in the assets of the organization, e g., a reversionary interest provided for in the articles of incorporation of a nonprofit corporation

(3) The term ,control includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise. The facts and circumstances in each case must be examined to ascertain whether legal or effective control exists Since a determination made in a specific case represents a conclusion based on the entire body of facts and circumstances involved, such determination should not be used as a precedent in other cases unless the facts and circumstances are substantially the same. Organizations, whether proprietary or nonprofit, are considered to be related through control to their directors in common.

(4) Costs applicable to services, equipment, facilities, and supplies furnished to the contracted provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization However, the cost must not exceed the price of comparable services, equipment, facilities, or supplies that could be purchased or leased elsewhere The purpose of this principle is twofold: to avoid the payment of a profit factor to the contracted provider through the related organization (whether related by common ownership or control), and to avoid payment of artificially inflated costs which may be generated from less than arm's-length bargaining The related organization's costs include all reasonable costs, direct and indirect, incurred in the furnishing of services, equipment, facilities, and supplies to the provider. The intent is to treat the costs incurred by the supplier as if they were incurred by the contracted provider itself. Therefore, if a cost would be unallowable if incurred by the contracted provider itself, it would be similarly unallowable to the related organization. The principles of reimbursement of contracted provider costs described throughout this title will generally be followed in determining the reasonableness and allowability of the related organization's costs, where application of a principle in a nonprovider entity would be clearly inappropriate.

(5) An exception is provided to the general rule applicable to related organizations. The exception applies if the contracted provider demonstrates on each cost

report by convincing evidence to the satisfaction of DHS that certain criteria have been met. If all of the conditions of this exception are met, then the charges by the supplier to the contracted provider for such services, equipment, facilities, or supplies are allowable costs. If Medicare has made a determination that a related party situation does not exist or that an exception to the related party definition was granted, the department will review the determination made by Medicare to determine if it is applicable to the current situation of the contracted provider and in compliance with this subsection (relating to Related party transactions). In order to have the Medicare determination considered for approval by the department, a copy of the applicable Medicare determination must accompany each affected cost report submitted to the department, along with evidence supporting the Medicare determination for the current cost report period. If the exception granted by Medicare no longer is applicable due to changes in circumstances of the contracted provider or because the circumstances do not apply to the contracted provider, the department may choose not to accept the Medicare determination. The contracted provider must demonstrate that the following criteria have been met.

(A) The supplying organization is a bona fide separate organization. This means that the supplier is a separate sole proprietorship, partnership, joint venture, association or corporation and not merely an operating division of the contracted provider organization.

(B) A majority of the supplying organization's business activity of the type carried on with the contracted provider is transacted with other organizations not related to the contracted provider and the supplier by common ownership or control and there is an open, competitive market for the type of services, equipment, facilities, or supplies furnished by the organization. In determining whether the activities are of similar type, it is important also to consider the scope of the activity The requirement that there be an open, competitive market is merely intended to assure that the item supplied has a readily discernible price that is established through arm's-length bargaining by well-informed buyers and sellers

(C) The services, equipment, facilities, or supplies are those which commonly are obtained by entities such as the contracted provider from other organizations and are not a basic element of contracted client care ordinarily furnished directly to clients by such entities. This requirement means that entities such as the contracted provider typically obtain the services, equipment, facilities, or supplies from outside sources, rather than producing them internally.

(D) The charge to the contracted provider is in line with the charge of such services, equipment, facilities, or supplies in the open, competitive market and no more than the charge made under comparable circumstances to others by the organization for such services, equipment, facilities, or supplies.

(6) Disclosure of all related-party information on the cost report is required for all costs reported by the contracted provider, including related-party transactions occurring at any level in the provider's organization, (e.g , the central office level, and the individual contracted provider level). The contracted provider must make available, upon request, adequate documentation to support the costs incurred by the related party. Such documentation must include an identification of the related person's or organization's total costs, the basis of allocation of direct and indirect costs to the contracted provider, and other business entities served. If a contracted provider fails to provide adequate documentation to substantiate the cost to the related person or organization, then the reported cost is unallowable. For further guidelines regarding adequate documentation, refer to §20.105(b)(2) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(7) When calculating the cost to the related organization, the cost-determination guidelines specified in §20.102 and §20.103 of this title (relating to General Principles of Allowable and Unallowable Costs and Specifications for Allowable and Unallowable Costs) apply.

(j) Cost Allocation. Direct costing must be used whenever reasonably possible. Direct costing means that allowable costs, direct or indirect, incurred for the benefit of, or directly attributable to, a specific business component must be directly charged to that particular business component. In the case of direct costs as defined in subsection (f)(3) of this section, direct costing is required. In the case of indirect costs as defined in subsection (f)(4) of this section, it is necessary to allocate these costs either directly or as a pool of costs across those business components sharing in the benefits.

(1) 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.

(A) The allocation method should be a reasonable reflection of the actual business operations Allocation methods that do not reasonably reflect the actual business operations and resources expended toward each unique business entity are not acceptable. Allocated costs are adjusted if DHS considers the allocation method to be unreasonable. An indirect allocation method approved by some other department, program, or governmental entity is not automatically approved by DHS for cost-reporting purposes

(B) DHS reviews each cost-reporting allocation method on a case-by-case basis in order to ensure that the reported costs fairly and reasonably represent the operations of the contracted provider. If in the course of an audit it is determined that an existing or approved allocation method does not fairly and reasonably represent the operations of the contracted provider, then an adjustment to the allocation method will be made consistent with subsection (f)(3)-(4) of this section. A contracted provider may request an informal review, and subsequently an appeal, of a decision concerning its allocation methods in accordance with §20.110 of this title (relating to Informal Reviews and Formal Appeals).

(C) 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.

(D) Any change in cost-reporting allocation methods from one year to the next must be fully disclosed by the contracted provider on its cost report, must be accompanied by a written explanation of the reasons and justification for such change, and must be accompanied by written prior approval from DHS's Rate Analysis Department.

(i) Requests for approval of a provider's change in cost-reporting allocation method must be received by the Rate Analysis Department prior to the end of the contracted provider's fiscal year. Requests for approval of allocation methods will not be acceptable as a basis for the extension of the cost report due date.

(ii) The Rate Analysis Department will forward its written decision to the contracted provider within 45 days of its receipt of the provider's original written request. If sufficient documentation is not provided by the provider to verify the acceptability of the allocation method, then DHS may extend the decision time frame. However, an extension of the due date of the cost report will not be granted. Written

decisions made on or after the due date of the cost report will apply to the next year's cost report. A contracted provider may request an informal review, and subsequently an appeal, of a decision concerning its allocation methods in accordance with §20.110 of this title (relating to Informal Reviews and Formal Appeals).

(iii) Failure to disclose a change in an allocation method or failure to use the allocation method approved or required by DHS may be considered an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §19.2609 (relating to Vendor Hold) for nursing facilities or §20.111 of this title (relating to Administrative Contract Violations) for all other programs.

(E) Any new contracted provider submitting its first cost report must have its cost-reporting allocation methods approved by the DHS's Rate Analysis Department prior to submitting its first cost report. Submittal of a cost report for a new contracted provider without an approved allocation method is considered a failure to file a completed cost report in accordance with §20. 105(b)(4)(C) of this title (General Reporting and Documentation Requirements, Methods, and Procedures).

(i) Requests for approval of a new provider's cost report allocation methods must be received by the Rate Analysis Department 60 days prior to the due date of the cost report. Requests for approval of allocation methods will not be acceptable as a basis for the extension of the cost report due date.

(ii) The Rate Analysis Department will forward its written decision to the contracted provider within 45 days of its receipt of the provider's original written request. If sufficient documentation is not provided by the provider to verify the acceptability of the allocation method, then DHS may extend the decision time frame. However, an extension of the due date of the cost report will not be granted. Written decisions made on or after the due date of the cost report will apply to the next year's cost report. A contracted provider may request an informal review, and subsequently an appeal, of a decision concerning its allocation methods in accordance with §20.110 of this title (relating to Informal Reviews and Formal Appeals).

(2) Cost-reporting methods for allocating costs must be clearly and completely documented in the contracted provider's workpapers, with details as to how pooled costs are allocated to each segment of the business entity, for both contracted and noncontracted programs.

(A) If a contracted provider has questions regarding the reasonableness of an allocation method, that contracted provider should request written approval from the Rate Analysis Department prior to submitting a cost report utilizing the allocation method in question. Requests for approval must be received by the Rate Analysis Department prior to the end of the contracted provider's fiscal year. Requests for approval of allocation methods will not be acceptable as a basis for the extension of the cost report due date.

(B) The Rate Analysis Department will forward its written decision to the contracted provider within 45 days of its receipt of the original written request. If sufficient documentation is not provided by the provider to verify the acceptability of the allocation method, DHS may extend the decision time frame. However, an extension of the due date of the cost report will not be granted. Written decisions made on or after the due date of the cost report will apply to the next year's cost report. A contracted provider may request an informal review, and subsequently an appeal, of a decision concerning its allocation methods in accordance with §20.110 of this title (relating to Informal Reviews and Formal Appeals).

(3) When a building is shared and the building usage is separate and distinct for each entity using the building, the building costs, such as rent, depreciation, utilities, maintenance, and insurance, should be allocated based upon square footage and may not be allocated with other indirect costs as a pool of costs. When the same building space is shared by various entities, the shared building costs, such as rent, depreciation, utilities, maintenance, and insurance, should be allocated using a reasonable method which reflects the actual usage, such as an allocation based on time in shared activity areas or meals served in shared dining and kitchen areas.

(4) Where costs are shared, are not directly chargeable and are allocated as a pool of costs, the following allocation methods are acceptable for cost-reporting purposes.

(A) If all the business components of a contracted provider have equivalent units of equivalent service, indirect costs must be allocated based upon each business component's units of service. For example, if a provider had two nursing facilities, indirect costs requiring allocation as a pool of costs must be allocated based upon each nursing facility's units of service, since the units of service are equivalent units and the services are equivalent services. If a provider had a nursing facility and a residential care program, indirect costs requiring allocation as a pool of costs could not be allocated based upon units of service because even though the units of service for a nursing facility and a residential care facility are equivalent units, the services are not equivalent services. If a home health agency has indirect costs requiring allocation as a pool of costs across its Medicare home health services and its Medicaid primary home care services, it could not use units of service to allocate those costs, since neither the units of service nor the services are equivalent.

(B) If all of a contracted provider's business components are labor-intensive without programmatic residential facility or residential building costs, the contracted provider must allocate its indirect costs requiring allocation as a pool of costs based either on each business component's pro rata share of salaries or labor costs or on a cost-to-cost basis.

(i) For cost-reporting cost allocation purposes, the term "salaries" includes wages paid to employees directly charged to the specific business component. The term "salaries" also includes fees paid to contracted individuals, excluding consultants, who perform services routinely performed by employees, which are directly charged to the specific business component. The term "salaries" does not include payroll taxes and employee benefits associated with the wages of employees.

(ii) For cost-reporting cost-allocation purposes, the term "labor costs" includes salaries as defined in subparagraph (B)(i) of this paragraph, plus the payroll taxes and employee benefits associated with the wages of the employees.

(iii) The cost-to-cost method allocates costs based upon the percentage of each business component's directly-charged costs to the total directly-charged costs of all business components.

(C) If a contracted provider's business components are mixed, with some being labor-intensive and others having a programmatic residential or institutional component, the contracted provider must allocate its indirect costs requiring allocation as a pool of costs based upon the ratio of each business component's total costs less that business component's facility or building costs, as related to the contracted provider's total business component costs less facility or building costs for all the contracted provider's business components.

(D) In order to achieve a more accurate and representative reporting of costs than results from allocating indirect costs as a pool of costs, a provider may

choose to allocate its indirect shared expenses on a functional basis. For example, costs of a central payroll operation could be allocated to all business components based on the number of checks issued; the costs of a central purchasing function could be allocated based on the dollar amount of purchases made or requisitions handled; payroll costs for an employee working across business components could be allocated based upon that employee's time sheets and/or a documented time study; food costs could be allocated based upon the number of meals served; transportation equipment costs could be allocated based upon mileage logs.

(E) Because the determination of reimbursement is based on cost data, allocation methods based upon revenue streams are inappropriate and unallowable.

(k) Net expenses. Net expenses are gross expenses less any purchase discounts or returns and allowances. Purchase discounts are cash discounts reducing the purchase price as a result of prompt payment, quantity purchases, or for other reasons. Purchase returns and allowances are reductions in expenses resulting from returned merchandise or merchandise which is damaged, lost, or incorrectly billed. Only net expenses may be reported on the cost report. Expenses reported on the cost report must be adjusted for all such purchase discounts or returns and allowances.

*§20.103. Specifications for Allowable and Unallowable Costs.*

(a) Introduction. The following list of allowable and unallowable costs is not comprehensive but serves as a guide and clarifies certain key expense areas. If a particular type of expense is classified as unallowable for purposes of reporting on a cost report, it does not mean that individual contracted providers may not make such expenditures. Except where specific exceptions are noted, the allowability of all costs is subject to the general principles specified in §20.102 of this title (relating to General Principles of Allowable and Unallowable Costs). In addition, refer to program-specific allowable and unallowable costs, as applicable.

(1) Accounting and auditing fees. See subsection (b)(2)(C)(i) of this section.

(2) Advertising and public relations. See subsection (b)(13) of this section.

(3) Amortization expense. See subsection (b)(7) of this section.

(4) Bad debt expense. See subsection (b)(17)(M) of this section.

(5) Boards of directors. See subsection (b)(2)(E) of this section.

(6) Bonuses. See subsection (b)(1)(A)(i) of this section.

(7) Central office costs. See subsection (b)(4) of this section.

(8) Charity allowance. See subsection (b)(17)(N) of this section.

(9) Compensation of employees See subsection (b)(1) of this section.

(10) Compensation of owners and related parties. See subsection (b)(2) of this subsection.

(11) Compensation of outside consultants. See subsection (b)(2)(C) of this section.

(12) Courtesy allowance. See subsection (b)(17)(N) of this subsection.

(13) Depreciation expense. See subsection (b)(7) of this section.

(14) Donated revenues. See subsection (b)(15) of this section.

(15) Donated services, supplies, and assets. See subsection (b)(16) of this section.

(16) Dues or contributions to organizations. See subsection (b)(11) of this section.

(17) Employee relations expenses. See subsection (b)(17)(A) of this section.

(18) Employment-related taxes. See subsection (b)(9)(B) of this section.

(19) Endowment income. See subsection (b)(15) of this section.

(20) Expenses not related to contracted services. See subsection (b)(17)(H) of this section.

(21) Fines and penalties. See subsection (b)(17)(G) of this section.

(22) Franchise tax. See subsection (b)(9)(C) of this section.

(23) Finance charges. See subsection (b)(8)(E) of this section.

(24) Franchise fees. See subsection (b)(17)(C) of this section.

(25) Fringe benefits. See subsection (b)(1)(A)(iii) of this section.

(26) Fundraising activities. See subsection (b)(14) of this section.

(27) Gains on disposal of assets. See subsection (b)(7)(F) of this section.

(28) Gifts. See subsection (b)(15) of this section.

(29) Goodwill. See subsection (b)(7) and (17)(C)(ii) of this section.

(30) Grants, gifts and income from endowments. See subsection (b)(15) of this section.

(31) In-kind donations. See subsection (b)(16) of this section.

(32) Insurance expense. See subsection (b)(10) of this section.

(33) Interest expense. See subsection (b)(8) of this section.

(34) Legal fees. See subsection (b)(2)(C)(ii) of this section.

(35) Life insurance. See subsection (b)(10)(G) of this section.

(36) Liquidation expenses and awards. See subsection (b)(17)(I) of this section.

(37) Lobbying costs. See subsection (b)(17)(J) of this section.

(38) Losses on disposal of assets. See subsection (b)(7)(F) of this section.

(39) Losses due to theft. See subsection (b)(17)(L) of this section.

(40) Management fees. See subsection (b)(3) of this section.

(41) Medicaid as payor of last resort. See subsection (b)(18) of this section.

(42) Medical supplies and medical costs. See subsection (b)(17)(F) of this section.

(43) Nonpaid workers. See subsection (b)(2)(D) of this section.

(44) Operating Revenue. See subsection (b)(15)(D) of this section.

(45) Organization costs. See subsection (b)(17)(B) of this section.

(46) Payroll taxes and insurance. See subsection (b)(1)(A)(ii) of this section.

(47) Penalties. See subsection (b)(17)(G) of this section.

(48) Planning and evaluation expenses. See subsection (b)(7)(E) of this section.

(49) Promotional activities. See subsection (b)(14) of this section.

(50) Public relations. See subsection (b)(13) of this section.

(51) Repairs and maintenance. See subsection (b)(6) of this section.

(52) Research and development costs. See subsection (b)(17)(E) of this section.

(53) Salaries and wages. See subsection (b)(1) and (2) of this section.

(54) Self-insurance. See subsection (b)(10)(B) of this section.

(55) Staff training costs. See subsection (b)(12)(A) of this section.

(56) Startup costs. See subsection (b)(17)(D) of this section.

(57) Tax expense and credits. See subsection (b)(9) of this section.

(58) Travel costs. See subsection (b)(12)(B) of this section.

(59) Utilities. See subsection (b)(5) of this section.

(60) Volunteers. See subsection (b)(2)(D) of this section.

(61) Voucher-paid expenses. See subsection (b)(17)(K) of this section.

(62) Workers' compensation insurance. See subsection (b)(10) of this section.

(b) Allowable and unallowable costs.

(1) Compensation of employees. Compensation includes both cash and non-cash forms of compensation subject to federal payroll tax regulations. Compensation includes wages and salaries (including bonuses); payroll taxes and insurance; and fringe 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.

(A) Allowable compensation of employees is compensation paid to employees in arm's-length transactions as nonowners and non-related parties and is subject to the reasonable and necessary costs which must be incurred by providers in the provision of contracted client services. Guidelines for compensation of owners and related parties are specified in subsection (b)(2) of this section.

(i) A bonus is a type of compensation granted to employees as a wage enhancement. Bonuses paid to employees in arm's-length transactions are allowable costs, subject to the reasonable and necessary costs which must be incurred by providers in the provision of contracted client services. In determining the employee classification type, part-time employees may be considered a different classification type than full-time employees. To be allowable, bonuses to owners and/or related parties:

(I) must not represent any form of profit sharing and must not be determined on the level of profit earned by the contracted provider;

(II) effective with the 1996 cost report, must be clearly defined in a written agreement or employment policy;

(III) must not be made only to related parties, in which case the bonuses are unallowable costs;

(IV) must be based upon the same criteria for all members of the same employee classification type;

(V) must be made available to all employees of the same classification type, unless the employee classification type predominantly consists of related parties, in which case the bonuses are unallowable costs; and

(VI) must not discriminate in favor of certain employees, such as employees who are officers, stockholders, or the highest paid individual(s) of the organization.

(ii) Payroll taxes and insurance are described in paragraph (9) of this subsection, concerning tax expense and credits, and paragraph (10) of this subsection.

(iii) Fringe benefits are amounts paid to or on behalf of an employee, in addition to direct salary or wages, and from which the employee, his dependent, or his beneficiary derives a personal benefit before or after the employee's retirement or death.

(I) Fringe benefits paid to employees in arm's length transactions as nonowners and non-related parties are allowable costs, subject to the reasonable and necessary costs which must be incurred by providers in the provision of contracted client care. To be allowable, fringe benefits paid to owners and/or related parties must not discriminate in favor of certain employees, such as employees who are officers, stockholders, or the highest paid individual(s) of the organization.

(II) Allowable fringe benefits are reported on cost reports either as salaries and/or wages, as employee benefits, or as costs applicable to specific cost areas. Any fringe benefit subject to payroll taxes is reported as salary and wages. Allowable fringe benefits which are routinely reported as salaries and wages include paid vacations, paid holidays, sick leave, voting leave, court or jury duty leave, and/or all-inclusive paid days, as specified in subclause (III)(-c-) of this clause. Allowable fringe benefits which are routinely reported as employee benefits include employer contributions to certain deferred compensation plans, as specified in subclause (III)(-a-) of this clause, employer contributions to an employee retirement fund or certain pension plans, as specified in subclause (III)(-b-) of this clause, and costs of certain employer-paid health, life, and disability insurance premiums, as specified in subclause (III)(-f-) of this clause. The contracted provider's unrecovered cost of meals and room and board furnished to direct care employees are fringe benefits which are reported as costs applicable to specific cost areas, as specified in subclause (III)(-e-) of this clause, unless they are subject to payroll taxes, whereas they are reported as salaries and wages.

(III) Fringe benefits include the following:

(-a-) Employer contributions to certain deferred compensation plans. Deferred compensation is remuneration currently earned by an employee but which is not received until a subsequent period, usually after retirement. For the cost to be allowable, the deferred compensation plan must be formal, established, and maintained by the contracted provider and communicated to all eligible employees. A formal plan is one that is provided for in a written agreement executed between the contracted provider and the participating employees. The plan must:

(-1-) prescribe the method for calculating all contributions to the fund;

(-2-) be funded with contributions made systematically to a funding agency outside the contracted provider's ownership or control, such as a trustee, an insurance company, or a custodial bank account;

(-3-) provide for the protection of the plan's assets;

(-4-) designate the requirements for vested benefits;

(-5-) provide the basis for the computation of the amounts of benefits to be paid;

(-6-) be expected to continue despite normal fluctuations in the contracted provider's economic experience; and

(-7-) use all fund contributions and earnings for the sole benefit of the participating employees. Contributions made during the cost-reporting period to a deferred compensation plan meeting the requirements specified in subitems (-1-)-(-7-) of this item which represent legal obligations of the contracted

provider and which are clearly enumerated as to dollar amount are allowable costs and should be reported on cost reports as employee benefits. Reasonable trustee or custodial fees paid by the contracted provider will be allowed as an administrative cost. However, such fees will not be allowable where the deferred compensation plan provides that they will be paid out of the corpus or earn-earnings of the fund.

(-b-) Employer contributions to an employee retirement fund or certain pension plans. A pension plan is a type of deferred compensation plan which is established and maintained by the employer to provide systematic payment of definitely determinable benefits to its employees over a period of years, or for life, after retirement. Such a plan may include disability, withdrawal, option for lump-sum payment, or insurance or survivorship benefits incidental and directly related to the pension benefits. A pension plan must meet all the requirements of a deferred compensation plan. All employees' pension fund rights must be nonforfeitable after such time as they vest under the plan. Pension fund rights cannot be contingent on continuance of employment or other factors. Only the amount the contracted provider or employer contributed to the pension fund during the reporting period is allowable and should be reported as an employee benefit. To be allowable, contributions representing the employee's share cannot revert to the contracted provider. However employer-paid contributions can revert to the contracted provider in the event an employee does not vest.

(-c-) Paid vacations, paid holidays, sick leave, voting leave, court or jury duty leave, and/or all-inclusive paid days, all are reported as employee salaries and/or wages rather than as employee benefits, as follows:

(-1-) A vacation benefit is a right granted by an employer to an employee to be absent from his job for a stipulated period of time without loss of pay or to be paid an additional salary in lieu of taking a vacation. The contracted provider's vacation policy must be consistent among all employees of a specific category. Vacation expense subject to payroll taxes must be reported as salaries and wages. Accrued vacation expense not yet subject to payroll taxes 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.

(-2-) The cost of sick leave taken, or payment in lieu of sick leave taken, is not to exceed the salary or wage the employee would have earned had they reported for work. Sick leave costs subject to payroll taxes must be reported as salaries and wages. Accrued sick leave costs not yet subject to payroll taxes 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.

(-3-) A formal plan for all-inclusive paid days off (PDO) is one under which all employees earn accrued vested leave, or payment in lieu of leave taken, for an unallocated combination of occasions such as illness, medical appointments, holidays, vacations, family leave, and care of a sick child, based on actual hours worked. The cost of PDO subject to payroll taxes must be reported as salaries and wages. Accrued costs of PDO not yet subject to payroll taxes 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.

(-d-) Provider-paid instructional courses benefiting the employee's interest. Costs related to provider-paid instructional courses for the benefit of the employee only are unallowable costs. Refer to paragraph (12)(A) of this subsection, concerning staff training costs.

(-e-) Contracted provider's unrecovered cost of meals and room and board furnished on-site to direct care employees. Any reasonable unrecovered cost of meals and/or room and board furnished on-site by a contracted provider to its direct care employees, which are equivalent to the meals and/or room and board provided to clients, are allowable costs since they are related to client care in that such reasonable costs are appropriate and helpful in developing and maintaining the contracted provider's operations to deliver contracted services. Such allowable costs should be reported in the cost area where the costs were incurred, such as meal costs being reported in the cost area associated with food and meal preparation and room and/or board costs being reported in the cost area associated with building costs.

(-f-) Costs of health, disability and life insurance premiums paid or incurred by the contracted provider if the benefits of the policy are payable to the employee or his beneficiary. Report allowable health, disability, and life insurance premium costs as employee benefits. Refer to paragraph (10) of this subsection, concerning insurance expense.

(B) Compensation of employees that is not clearly enumerated as to dollar amount or which represent profit or surplus revenue distributions are unallowable costs. Accrued expenses that are not legal obligations of the contracted provider are unallowable costs, including any form of profit sharing and the accrued liabilities of unfunded deferred compensation plans.

(2) 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 fringe 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. Allowable compensation must be reported as salaries and not as management fees.

(A) Allowable compensation of owners and related parties.

(i) 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 for the purposes of this subparagraph. Allowable compensation for a related party, as defined in §20.102(i) of this title (relating to General Principles of Allowable and Unallowable Costs), a sole proprietor-employee, a partner-employee, or a corporate stockholder-employee is governed by the principles that the services rendered are necessary functions and that the remuneration is the reasonable value of the services rendered.

(I) A function is deemed necessary when, if the owner or related party had not performed said function, the contracted provider would have had to employ another person to perform that function. To be necessary, a function must pertain to direct or indirect activities in the provision or supervision of contracted client services. The fact that an owner may have potential supervisory and managerial authority and responsibility is not as important as the manner in which this authority and responsibility is actually exercised. As an example, the right of the owner-administrator to overrule decisions does not solely constitute a basis for recognition of compensation comparable to nonowner-administrators.

(II) The test of reasonableness requires that the compensation of owners or related parties be such an amount

as would ordinarily be paid for comparable services performed by nonowners or unrelated parties. Reasonable compensation is limited to the fair market value of services rendered by the owner or related party in connection with contracted client care. Education and experience of the owner are pertinent only as they relate to the job being performed and the services being rendered. For example, where an owner-administrator is also a physician or a nurse or a lawyer, but the services evaluated are administrative in nature rather than the actual practice of medicine or nursing or law, the allowable compensation is based on the compensation nonphysician or nonnurse or nonlawyer administrators receive rather than on the rate physicians or nurses or lawyers receive for their professional services.

(ii) The compensation must be for services performed by the related party, owner, partner, or stockholder that do not duplicate services performed by another employee of the contracted provider.

(iii) Compensation for "full-time" service requires that at least 40 hours per week be devoted to the duties of the position for which compensation is requested. For owners devoting less than 40 hours per week to the position, allowable compensation is limited to the proportion of 40 hours actually devoted to the contract services. Documentation regarding owners and related parties must be kept in accordance with §20.105(b)(2)(B)(xi) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(iv) Compensation must be in accordance with paragraph (1)(A) of this subsection concerning compensation of employees, must be made in regular periodic payments, must be subject to payroll or self-employment taxes, and must be verifiable by adequate documentation maintained by the contracted provider.

(B) Unallowable compensation of owners and related parties.

(i) Forms of compensation that are not clearly enumerated as to dollar amount or which represent profit or surplus revenue distributions are unallowable costs.

(ii) Compensation in the form of salaries, benefits, or any form of perquisite provided to owners, partners, officers, directors, stockholders, employees, or others who do not provide services directly to clients or who do not provide services required in the normal conduct of operations to provide contracted client services, is an unallowable cost. Services which would be required in the normal conduct of operations to provide contracted client services would include expenses such as administration of the program or supervision of direct care staff.

(C) Compensation for outside consultants and fees for services provided by outside vendors. Allowable compensation for outside consultants and contracted services must meet the criteria in §20.102 of this title (relating to General Principles of Allowable and Unallowable Costs). Specific criteria for certain types of compensation of outside consultants and contracted services are as follows:

(i) Accounting and audit fees.

(I) Allowable accounting and audit fees. Fees for preparation of business tax reports and returns, financial statements, and cost reports are allowable costs. Audit fees associated with the performance of a financial audit are allowable costs.

(II) Unallowable accounting and audit fees. Expenses related to the preparation of personal tax returns are unallowable costs as are certain taxes. Refer to paragraph (9) of this subsection, concerning tax expense and credits. Audit fees associated with the performance of a single audit are unallowable costs. The cost attributable to a financial audit that was conducted along with a single audit is allowable if the cost of the financial audit can be identified separately from the cost attributable to the single audit. Accounting fees and related costs associated with litigation between a provider and a governmental entity are unallowable. Accounting costs associated with any other unallowable costs are also unallowable. Fees related to the preparation of annual reports, reports to stockholders or other interested parties, or for investment management are unallowable costs.

(ii) Legal fees. Legal retainers are not allowable in and of themselves, but rather must be documented as specified in §20.105(b)(2)(B) (viii) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures). Legal costs associated with litigation between a provider and a governmental entity are unallowable. Legal costs associated with any other unallowable costs are also unallowable.

(D) Value of services of nonpaid workers. Since the contracted provider incurs no actual costs for nonpaid and/or volunteer workers, the value of the nonpaid work is not an element of cost; and the value of such nonpaid work is an unallowable cost.

(E) Boards of directors. Boards of directors fees are unallowable costs. Errors and omissions (liability) insurance for boards of directors are allowable costs. Travel and per diem expenses related to board members will be allowable up to the maximum allowable travel guidelines as stated in paragraph (12)(B) of this subsection.

(3) Management fees.

(A) Allowable management fees. Reasonable management fees paid to unrelated parties are allowable costs. Allowable management fees paid to related parties are the actual costs to the related party for the materials, supplies, and services provided directly to the individual contracted provider. Any related party compensation or owner compensation included in allowable management fees paid to related parties must follow the guidelines specified in §20.102(i) of this title (relating to General Principles of Allowable and Unallowable Costs) and in paragraph (2) of this subsection, concerning compensation of owners and related parties. Expenses for management provided by the contracted provider's central office must be reported as central office costs on the cost report. Cash management fees related to minimizing interest costs and banking expenses in the management of operating revenue necessary for contracted services are allowable costs.

(B) Unallowable management fees. Fees for management of personal investments or investments not necessary for the provision of contracted services are unallowable costs.

(4) Central office costs. A chain organization consists of a group of two or more contracted entities which are owned, leased or controlled through any other arrangement by one organization. A chain may also include business organizations which are engaged in other activities and which are not contracted program entities. Central offices of a chain organization vary in the services furnished to the components in the chain. The relationship of the central office to an entity providing contracted services is that of a related party organization to a contracted provider. Central offices usually furnish central management and administrative services such as central accounting, purchasing, personnel services, management direction and control, and other necessary services. To the extent the central office furnishes services related directly or indirectly to contracted client care, the reasonable costs of such services are allowable. Allowable central office costs include costs directly related to those services necessary for the provision of client

care for contracted services in Texas and an appropriate share of allowable indirect costs. Where functions of the central office have no direct or indirect bearing on delivering contracted client care, the cost for those functions are not allowable costs. Costs which are unallowable to the contracted provider are also unallowable as central office costs. Where a contracted provider is furnished services, facilities, or supplies from its central office, the costs allowed are subject to the guidelines of related party transactions in §20.102(i) of this title (relating to General Principles of Allowable and Unallowable Costs). Owner-employees and related parties receiving compensation for services provided through the central office are allowable to the extent provided in paragraph (2)(A) and (B) of this subsection, concerning compensation of owners and related parties.

(5) Utilities. To be allowable, the utilities must be used directly or indirectly in the provision of contracted services.

(6) Repairs and maintenance. For cost-reporting purposes, repairs and maintenance are categorized as ordinary or extraordinary (major) repairs and should be handled as follows.

(A) Ordinary repairs and maintenance are defined as outlays for parts, labor, and related supplies which are necessary to keep the asset in operating condition, but neither add materially to the use value of the asset nor prolong its life appreciably Ordinary repairs are recurring and usually involve relatively small expenditures. Ordinary repairs include, but are not limited to, painting, wall papering, copy machine repair, repairing an electrical circuit, or replacing spark plugs. Because maintenance costs and ordinary repairs are similar, they are usually combined for accounting purposes. Ordinary repairs may be expensed.

(B) Extraordinary repairs (major repairs) involve relatively large expenditures, are not normally recurring in nature, and usually increase the use value (efficiency and use utility) or the service life of the asset beyond what it was before the repair. Extraordinary repairs costing $1,000 or more, with a useful life in excess of one year, should be capitalized and depreciated. The cost of the extraordinary repair should be added to the cost of the asset and depreciated over the remaining useful life of the original asset. If the life of the asset has been extended due to the repair, the useful life should be adjusted accordingly. Extraordinary repairs include, but are not limited to, major vehicle overhauls, major improvements in a building's electrical system, carpeting an entire building, replacement of a roof, or strengthening the foundation of a building.

(7) Depreciation and amortization expense. For purchases made after the beginning of the contracted provider's fiscal year 1996, an asset valued at $1, 000 or more and with an estimated useful life of more than one year at the time of purchase costing less than $1,000 per item) must be depreciated or amortized, using the straight line method. In determining whether to expense or depreciate a purchased item, a contracted provider may expense any single item costing less than $1,000 or having a useful life of one year or less. Depreciation and amortization expenses for unallowable assets and costs are also unallowable, including amounts in excess of those resulting from the straight line method, capitalized lease expenses in excess of actual lease payments, and goodwill or any excess above the actual value of physical assets at the time of purchase. The minimum useful lives to be assigned to common classes of depreciable property are as follows:

(A) Buildings. A building's life must be reported as a minimum of 30 years, with a minimum salvage value of 10%. All buildings, excluding the value of the land, are uniformly depreciated on a 30-year life basis, regardless of the actual date of construction or original purchase. Exceptions to this policy are permissible when contracted providers choose a useful-life basis in excess of 30 years. An example of depreciation on a 30-year life basis is Figure 1: 40 TAC §20.103(b)(7)(A)

(B) Building equipment; buildings and grounds improvements and repairs; durable medical equipment, furniture, and appliances; and power equipment and tools used for buildings and grounds maintenance. Use minimum schedules consistent with "Estimated Useful Lives of Depreciable Hospital Assets," published by the American Hospital Association. Copies of this publication may be obtained by contacting American Hospital Publishing, Inc., 737 North Michigan Ave., Chicago, IL 60611. Leasehold improvements whose estimated useful lives according to the guidelines for depreciable hospital assets are longer than the term of the lease must be depreciated and/or amortized over the remaining life of the lease or the life of the leasehold improvement, whichever is longer. Building improvements which are not structural in nature and do not extend the depreciable life of the building, but whose estimated useful lives according to the guidelines for depreciable hospital assets are longer than the remaining depreciable life of the building, must be depreciated over the normal useful life of the building improvements, or the remaining life of the building, whichever is longer. Once the estimated useful life of the leasehold improvement has been established using the guidelines above, subsequent extensions of the lease period do not change the useful life of the leasehold improvement. Any exceptions to this policy shall be stated in each program-specific reimbursement methodology rules.

(C) Transportation equipment used for the transport of clients, staff, or materials and supplies utilized by the contracted provider. Cost reporting must reflect a minimum of three years for automobiles (including minivans); five years for light trucks and vans; and seven years for buses and airplanes. Depreciation expenses for transportation equipment not generally suited or not commonly used to transport clients, staff, or provider supplies are unallowable costs. This includes motor homes and recreational vehicles; sports automobiles, motorcycles; heavy trucks, tractors and equipment used in farming, ranching, and construction; and transportation equipment used for other activities unrelated to the provision of contracted client care, unless program-specific reimbursement methodology rules provide otherwise. Refer to §20.105(b)(2)(B)(iii) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures) for requirements for the maintenance of mileage logs and other documentation required to substantiate transportation equipment costs.

(i) Luxury automobiles are defined for cost-reporting purposes as passenger vehicles, excluding buses, with an historical cost at time of purchase or a market value at execution of the lease exceeding $30,000 when purchased or leased before January 1, 1996. For vehicles leased or purchased on or after January 1, 1996, luxury vehicles are defined as a base value of $30,000 with 2.0% being added (using the compound method) to the base value each January 1 beginning on January 1, 1997. Any amount above the definition of a luxury vehicle stated above is an unallowable cost When a passenger vehicle's cost exceeds the amount determined by the definition of a luxury vehicle stated above, the historical cost is reduced to the amount determined by the definition of a luxury vehicle. When a passenger vehicle's market value at the execution of the lease exceeds the amount determined by the definition of a luxury vehicle stated above, the allowable lease payment is limited to the lease amount for a vehicle with the base value as determined above, with substantiating documentation as specified in §20.105(b)(2)(B)(iv) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures). Luxury vehicles must be depreciated according to depreciation guidelines in this paragraph. Expenses for

passenger luxury vehicles will be allowable if the contracted provider maintains adequate mileage logs substantiating the use of the luxury vehicles to transport clients, contracted provider staff or provider supplies. Refer to §20 105(b)(2)(B)(iii) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures) for requirements for the maintenance of mileage logs. The base value does not include specialized equipment, such as wheelchair lifts, added to assist clients.

(ii) The estimated life of a previously owned (used) vehicle is the longer of the number of years remaining in the vehicle's depreciable life or three years. For example, if a 1994 van were purchased in 1995, it would have four years remaining in its five-year depreciable life and that would become the depreciable life for the used vehicle. If a 1994 minivan were purchased in 1995, it would have two years remaining in its three-year depreciable life and the depreciable life for the used vehicle would then be three years

(iii) Specialized equipment added to a vehicle to assist a client should be depreciated separately from the vehicle Wheelchair lifts have an estimated useful life of four years.

(D) Depreciation for the first reporting period. Depreciation for the first reporting period is based on the length of time from the date of acquisition to the end of the reporting period. Depreciation on disposal is based on the length of time from the beginning of the reporting period in which the asset was disposed to the date of disposal

(E) Planning and evaluation expenses Planning and evaluation expenses for the purchase of depreciable assets are allowable costs only where purchases are actually made and the assets are put into service in the provision of care by the provider for contracted services.

(F) Gains and losses. Gains and losses realized from the trade-in or exchange of depreciable assets are included in the determination of allowable cost. When an asset is acquired by trading-in an asset that was being depreciated, the historical cost of the new asset is the sum of the undepreciated cost of the asset traded-in plus any cash or other assets transferred or to be transferred to acquire the new asset. Losses resulting from the involuntary conversion of depreciable assets, such as condemnation, fire, theft, or other casualty, are includable as allowable costs in the year of involuntary conversion, provided the total aggregate allowable losses incurred in any cost-reporting period do not exceed $5,000 and provided the assets are replaced. If the total aggregate allowable losses in any cost-reporting period exceed $5,000, the total amount of the losses over $5, 000 is recognized as a deferred charge and treated as follows:

(i) If a depreciable asset is destroyed by an involuntary conversion beyond repair, then the amount of the loss over $5,000 must be capitalized as a deferred charge over the estimated useful life of the asset which replaces it. The allowable loss for a total casualty is the undepreciated cost of the asset, less insurance proceeds, gifts, and grants from any source as a result of the involuntary conversion. If the unrepairable asset is disposed of by scrapping, income received from salvage is treated as a reduction in the amount of the allowable loss. Conversely, where additional expense is incurred in the scrapping operation, such cost would be added to the allowable loss of the destroyed asset.

(ii) If a depreciable asset is partially destroyed or damaged as a result of an involuntary conversion, a reduction in its cost basis is assumed to have taken place. Therefore, the cost basis of the asset must be reduced to reflect the amount of the casualty loss, regardless of whether the loss is covered by insurance.

(I) The amount of the casualty loss is the difference between the fair market value immediately before the casualty and the fair market value immediately after the casualty; however, for cost-reporting purposes, the allowable loss is limited to the percent of loss in fair market value applied to the net book value of the asset at the time the casualty occurred. This method of calculating the allowable loss recognizes the actual reduction in the cost value of the asset rather than the reduction in replacement value.

(II) Any loss over $5,000 must be capitalized as a deferred charge and amortized over the useful life of the restored asset.

(III) The fair market value generally can be ascertained by competent appraisal. If no appraisal is made, the cost of repairs to the damaged property is acceptable as evidence of the loss of value if the repairs restore the property to its condition immediately before the casualty and, as a result of the repairs, the value of the property has not been increased. The amount of the allowable loss is then deducted from the cost basis of the asset before the casualty, to arrive at the adjusted cost basis of the asset. Any insurance proceeds received or recoverable must be deducted from the amount of the casualty loss to determine the gain or the loss.

(IV) Actual costs incurred in the restoration of an asset are added to the adjusted cost basis of the asset to arrive at the revised cost of the restored asset and capitalized over the remaining useful life of the restored asset.

(V) When the repairs materially improve or add to the value or utility of the property or appreciably prolong its useful life, the repairs must be depreciated over the estimated life of the repairs.

(VI) When the contracted provider maintains a self-insurance reserve fund, the amount of the casualty loss recognized as an allowable cost is limited to the lesser of the decrease in fair market value, as adjusted, of the damaged or destroyed asset or the amount of cash, and/or investments, comprising the accumulated balance of the self-insurance reserve account.

(VII) When an asset is sold before the end of its useful life and a gain is realized (the sales price is greater than the remaining allowable depreciation), no additional depreciation or expense is allowed.

(8) Interest expense. Reasonable and necessary interest on current and capital indebtedness is an allowable cost. In the case of allowable interest incurred on a loan, in order to be determined necessary, the loan must have been made to satisfy a financial need for a purpose reasonably related to contracted client care.

(A) For cost-reporting purposes, allowable interest expenses are limited to that net portion of interest accrued which has not been reduced or offset by interest income. To be allowable, the following requirements must be met.

(i) The loan must be supported by evidence in writing of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required and systematically made. Refer to §20.105(b)(2)(B) (ii) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures);

(ii) The loan must be made in the name of the contracted provider entity as maker or comaker of the note; and

(iii) The proceeds of the note or loan must be used for allowable costs

(B) Interest expense on a demand note is allowable if the loan is the result of an arm's-length transaction

(C) Where the lender is a related party, allowable interest is limited to the prevailing national average prime interest rate in effect at the time at which the loan contract was finalized, as reported by the United States Department of Commerce, Bureau of Economic Analysis, in the Survey of Current Business

(D) Interest costs incurred during the period of construction or enlarging of a building must be capitalized as part of the cost of the building

(E) Reasonable finance charges and service charges, together with interest on indebtedness, are allowable costs

(F) Other fees associated with obtaining an allowable loan, such as broker's fees to solicit financing, lender's fees, attorney's fees, and due diligence fees, are allowable costs

(G) Interest expenses on funds borrowed for purposes of investing in operations other than contracted services, on loans pertaining to unallowable items, and on borrowed funds creating excess working capital are unallowable costs

(9) Tax expense and credits

(A) Generally, taxes assessed against the contracted provider, in accordance with the levying enactments of Texas and lower levels of government and for which the contracted provider is liable for payment, are allowable costs Tax expense based on fines and penalties are unallowable costs

(B) Employment-related taxes such as FICA SPELL OUT, Workers' Compensation and Unemployment Compensation, are allowable costs Refer to paragraph (1)(A) of this subsection

(C) Franchise taxes are allowable costs. A franchise tax is a periodic assessment, as defined by the Texas Comptroller of Public Accounts and paid to the Texas State Treasurer, levied on the operation of a business in the State of Texas Franchise taxes do not refer to franchise fees, which are the costs associated with a company's granting the right to sell its products or services in a specified territory.

(D) Unallowable taxes include

(i) Federal income taxes and excess profit or surplus revenue based taxes, including any interest or penalties paid thereon. However, fees for preparation of business tax reports and business returns required by law are allowable.

(ii) State or local income and excess profit or surplus revenue based taxes However, fees for preparation of business tax reports and/or business returns are allowable

(iii) Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bonds, property transfers, issuance or transfer of stocks Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are, however, unallowable as tax expense

(iv) Taxes from which exemptions are available to the contracted provider

(v) Special assessments on land which represent capital improvements should be capitalized and depreciated over their estimated useful lives and are not allowable as tax expenses.

(vi) Taxes, such as sales taxes, levied against the client and collected and remitted by the contracted provider.

(vii) Self-employment taxes

(10) Insurance expense. This section covers the following types of insurance. property damage and destruction, fire and casualty; malpractice and comprehensive general liability; errors and omissions insurance covering boards of directors; theft insurance (fidelity bonds and burglary insurance); workers' compensation; transportation equipment insurance; life insurance for owners, officers, and key employees; health, disability; and unemployment compensation.

(A) Purchased and commercial insurance. The reasonable costs of insurance purchased from a commercial carrier or a nonprofit service corporation are allowable if resulting from an arm's-length transaction. The commercial carrier or nonprofit service corporation must meet the standards as set by the Texas Department of Insurance. Costs of insurance purchased from a limited purpose insurer are allowable if they are not in excess of the cost of available comparable commercial insurance premiums and meet the reasonable cost provisions If comparable insurance premiums are not available, the limited purpose insurer or captive insurance company must obtain an evaluation of the adequacy and reasonableness of its insurance premium by an independent actuary, commercial insurance company, or broker.

(B) Self-Insurance. Self-insurance is a means whereby a contracted provider undertakes the risk to protect itself against anticipated liabilities by providing funds in an amount equivalent to liquidate those liabilities. Self-insurance can also be described as being uninsured. To qualify as an allowable self-insurance plan, a contracted provider must enter into an agreement with an unrelated party that does not provide for the shifting of risk to the unrelated party designed to provide only administrative services to liquidate those liabilities and manage risks. Self-insurance costs for contracted providers who have received certificates of authority to self-insure from the Texas Workers' Compensation Commission are allowable costs. Self-insurance costs in excess of costs for similar, comparable coverage by purchased and/or commercial insurance premiums are unallowable costs. Documentation substantiating the cost of comparable coverage by purchased and/or commercial insurance premiums must be obtained and maintained as specified in §20 105(b)(2)(B)(ix) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(i) Costs related to self-insurance are allowable on a claims-paid basis. Contributions to the self-insurance fund or reserve which do not represent payments based on current liabilities are not considered actual incurred expenses and are not allowable costs. For cost-reporting purposes, self-insurance costs are reported on a cash basis. For cost-reporting purposes, compensation paid to employees who have been injured on the job is allowable and should be reported as compensation according to the type of compensation expense incurred in accordance with paragraphs (1) and (2) of this subsection.

(ii) For cost-reporting purposes, allowable employee-related paid claims, such as health insurance and workers' compensation costs, may either be directly charged to the business component in which the employee worked or may be allocated across all business components as an administrative expense. The method chosen to report these costs must remain consistent each year. Changes in the method for reporting those costs must be approved in accordance with §20.102(j) of this title (relating to General Principles of Allowable and Unallowable Costs).

(C) Determining self-insurance or purchased commercial insurance. There may be situations in which there is a fine line between self-insurance

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

(D) Reporting of insurance costs. All allowable insurance premium costs should be reported on cost reports, with amounts accrued for premiums, modifiers, and surcharges during the cost-reporting period being adjusted by any refunds and discounts actually received or settlements paid during the same cost-reporting period

(E) Losses in excess of coverage. When a contracted provider is not fully insured by a purchased commercial insurance policy, i.e., the provider's coverage includes coinsurance provisions and/or deductibles, the amount of allowable insurance costs reported for each cost-reporting period is subject to a cost ceiling.

(i) The cost ceiling for employee-related insurance, such as health insurance, or workers' compensation coverage, is either the amount that would have been incurred had the provider purchased full coverage for its entire business entity through a commercial insurance policy or an amount equal to 10% of the payroll for employees eligible for such coverage.

(ii) The cost ceiling for non-employee-related insurance, such as malpractice insurance, comprehensive general liability insurance, or property insurance, is the amount that would have been incurred had the provider purchased full coverage for its entire business entity through a commercial insurance policy.

(iii) If, during a cost-reporting period, a provider incurs allowable paid claims in excess of the applicable cost ceiling, the provider reports on its current cost report allowable insurance costs up to the amount of the applicable cost ceiling, with the allowable costs in excess of the applicable cost ceiling being carried forward to future cost-reporting periods. When, during a future cost-reporting period, a provider incurs allowable insurance costs in an amount less than the applicable cost ceiling, the provider reports on its cost report the allowable insurance costs (paid claims) incurred during that cost-reporting period plus any allowable carry forward amount up to the amount of the applicable cost ceiling, with any excess carry forward being carried forward to future cost reporting periods.

(iv) Documentation requirements are stated in §20.105(b)(2)(B)(ix) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(F) Absence of coverage. Where a contracted provider, other than a governmental provider, has no insurance protection, the reporting of the provider's paid claims must follow the guidelines stated in subparagraph (E) of this paragraph. For governmental providers, allowable paid claims for cost-reporting purposes include all claims paid during the cost-reporting period only if the provider demonstrates that it has a claims management and risk management program

(G) Life insurance costs.

(i) Unallowable life insurance costs. In general, premiums related to insurance on the lives of owners, officers, and key employees where the contracted provider is a direct or indirect beneficiary are unallowable costs.

(ii) Life insurance costs are allowable if:

(I) a contracted provider is required by a lending institution or other lender to purchase such insurance to guarantee the outstanding loan balance;

(II) the lending institution or other lender must be designated as the beneficiary of the insurance policy; and

(III) upon the death of the insured, the proceeds are restricted to paying off the balance of the loan.

(iii) Allowable insurance premiums are limited to premiums equivalent to that of a decreasing term life insurance policy needed to pay off the outstanding loan balance or that portion of the premium which can be equated to the premium for a similar face amount of a decreasing term life policy. In addition, the loan must be reasonable and necessary and must meet the criteria for allowable loans and interest expense as stated in paragraph (8) of this subsection.

(iv) Provider-paid premiums related to insurance on the lives of owners-employees, officers, and key employees where the individual's relatives or his estate are the beneficiary are considered to be employee benefits to the individual and are allowable costs to the extent such employee benefits are allowable. Provider-paid premiums related to insurance on the lives of owners-employees, officers, and key employees where required by a financial institution and the financial institution is the beneficiary is allowable

(H) Insurance costs pertaining to unallowable costs. Insurance costs pertaining to items of unallowable costs are themselves unallowable costs.

(I) Board of directors' insurance. Errors and omissions insurance (liability) on members of boards of directors is an allowable cost.

(11) Dues or contributions to organizations.

(A) Allowable dues and contributions to organizations. Costs of membership in professional associations directly and primarily concerned with the provision of services for which the provider is contracted are allowable. Allowable costs of memberships in such organizations include initiation fees, dues, and subscriptions to related professional periodicals. Allowable costs related to meetings and conferences whose primary purpose is to disseminate information for the advancement of contracted client care or the efficient operation of the contracted program include reasonable costs for meals and transportation in accordance with paragraph (12)(B) of this subsection and reasonable registration fees and other costs incidental to those functions. Dues or licensing fees related to maintaining the professional accreditation or license of an employee are allowable to the extent that the professional accreditation or license is directly related to and necessary for the performance of that employee's functions.

(B) Unallowable dues and contributions to organizations. Dues to non-professional organizations are unallowable. Assessments whose purpose is to fund lawsuits or any legal action against the state or federal government are unallowable. Portions of dues based on revenue or for the purposes of lobbying, or campaign contributions are unallowable costs. Costs of membership in civic organizations whose primary purpose is the promotion and implementation of civic objectives are unallowable. Dues or contributions made to any type of political, social, fraternal, or charitable organization are unallowable. Chamber of Commerce dues are unallowable. Franchise fees are not considered dues or contributions to organizations.

(C) Dues to purchasing organizations or buying clubs. Allowable dues to purchasing organizations or buying clubs are limited to the pro-rata amount representing purchases made for use in providing contracted services.

(12) Training and travel costs.

(A) Staff training costs.

(i) Staff training costs refer to costs associated with educational activities for provider staff. To qualify as an allowable staff training cost, the training must:

(I) have a direct relationship with the employee's job responsibilities, thereby increasing the quality of contracted client care or the efficient operation of the contracted provider. Management training, if it is designed to enhance quality or improve administration and is relevant to the contracted service, is an allowable cost. The following apply to staff training costs.

(-a-) Non-related party staff. Costs of tuition, books, and related fees for courses required to complete the designated degree or certification are allowable The degree or certification must be necessary to the provision of contracted client services of the contracted provider. An example would be any course required to be taken by a licensed vocational nurse (LVN) working toward a degree as a registered nurse (RN) where RN services are necessary to deliver services as required under the contract.

(-b-) Related party staff. Allowable costs are restricted to specific courses which have a direct relationship with the employee's job responsibilities. Examples of allowable staff training costs include tuition, books, and related fees for an accounting course for a bookkeeper and a management course for a supervisor. However, a history course for a bookkeeper, even though it may be a requirement for a college degree in accounting or business, is unallowable.

(II) be located within the state of Texas unless the purpose of the training is for staff training in contracted client care-related services or quality assurance which is not available in the State of Texas. All costs for training outside the continental United States are unallowable costs. For further guidelines regarding adequate documentation, refer to §20.105(b)(2)(B)(vi) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(ii) Staff training may be conducted within the provider setting or offsite. It may be operated by the contracted provider, provided by an accredited academic or technical institution, or conducted by a recognized professional organization for the particular training activity. Workshops on particular contracted client services, health applications, on-the-job safety, data processing, accounting, the Texas Department of Human Services (DHS) programmatic or cost related training, supervisory techniques, and other administrative activities are examples of allowable types of training Costs of orientation, on-the-job training, and inservice training are recognized as normal operating costs and are allowable training costs.

(iii) For staff training conducted within the provider setting, allowable training costs include, but are not limited to, instructor and consultant fees, training supplies, and visual aids. For offsite training, allowable costs include costs such as allowable travel costs, registration fees, seminar supplies, and classroom costs. For additional guidelines regarding allowable travel costs, please refer to paragraph (12)(B) of this subsection.

(iv) Staff training costs must be reported as net costs, having been offset by any reimbursement from grants, tuitions, or donations received for staff educational purposes.

(v) Nursing facility nurse aide training. Refer to paragraph (17)(K) of this subsection and program-specific reimbursement methodology rules.

(vi) Client prevocational, vocational, and educational costs. Refer to program-specific reimbursement methodology rules for guidelines on allowability.

(B) Travel costs.

(i) Maximum allowable travel costs for employees and members of the Board of Directors are as follows:

(I) 150% of the limits established by the Texas Legislature for non-exempt state employees, with respect to hotel costs and per diem rates.

(II) the maximum allowable mileage reimbursement amount set by the Texas Legislature for non-exempt state employees.

(ii) Out-of-state travel costs are unallowable, unless the purpose of the travel is for staff training in contracted client-care-related services or in quality assurance which is not available in the state of Texas or for the purpose of delivering direct contracted client services within 25 miles of the Texas border with adjoining states. All costs for travel outside the continental United States are unallowable costs, with the singular exception of travel required for the delivery of direct contracted client services within 25 miles of the Texas-Mexico border.

(iii) Expenses for private aircraft are allowable only if:

(I) all criteria in flight logs are maintained as specified in §20.105(b)(2)(B)(iii) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures); and

(II) the contracted provider furnishes documentation demonstrating that the expenses for travel via private aircraft are not greater than those for commercial alternatives or ground transportation at the time the travel took place. Documentation demonstrating the cost of ground transportation may include the staff costs for the employee's time during the trip, and for commercial alternatives, the staff costs for the employee's time during the trip and at the terminal/station.

(13) Advertising and public relations.

(A) Allowable advertising and public relations.

(i) Costs of advertising to meet statutory or regulatory requirements, such as program standards, rules, or contract requirements, are allowable costs.

(ii) Informational listings of contracted providers in a telephone directory, including yellow page listings up to one-eighth of a page per telephone directory in the provider's service area or in a directory of similar facilities in a given area are allowable if the listings are consistent with practices that are common and accepted in the industry.

(iii) Costs of advertising for the purpose of recruiting necessary personnel are allowable costs. Refer to the definition of necessary in §20.102(f)(2) of this title (relating to General Principles of Allowable and Unallowable Costs).

(iv) Costs of advertising for procurement of items related to contracted client care, and for sale or disposition of surplus or scrap material are treated as adjustments of the purchase or selling price.

(v) Costs of advertising incurred in connection with obtaining bids for construction or renovation of the contracted provider's facilities should be included in the capitalized cost of the asset. Refer to paragraph (7) of this subsection.

(B) Unallowable advertising and public relations.

(i) Costs of advertising of a general nature designed to invite physicians to utilize a contracted provider's facilities in their capacity as independent practitioners;

(ii) Costs of advertising incurred in connection with the issuance of a contracted provider's own stock, or the sale of stock held by the contracted provider in another corporation are considered as reductions in the proceeds from the sale;

(iii) Costs of advertising to the general public which seeks to increase client utilization of the contracted provider's facilities;

(iv) Public relations costs;

(v) Any business promotional advertising; and

(vi) Costs of the development of logos or other company identification.

(14) Promotional and fundraising activities. Promotional refers to any activity whose intent is to advertise or aid in the development of the business. Expenses relating to fundraising and promotional activities are unallowable, including salaries, benefits, and payroll taxes for staff performing these activities. If a staff member performs these activities along with allowable activities, a portion of that staff member's salary must be allocated to these unallowable activities and as such not be reported on the cost report. Other expenses associated with these activities are also unallowable, including advertising, publicity, travel, and meals.

(15) Grants, gifts, and income from endowments and operating revenue.

(A) Restricted grants, gifts, and income from endowments from private sources used to purchase allowable program costs should not be deducted and offset from allowable costs prior to reporting on the cost report.

(B) Grants and contracts from federal, state or local government, such as transportation grants, United States Department of Agriculture grants, education grants, Housing and Urban Development grants, and Community Service Block Grants, should be offset, prior to reporting on the cost report, against the particular cost or group of costs for which the grant was intended. If federal funds are paid for the care of a specified client, those federal funds should not be offset prior to reporting on the cost report, unless otherwise specified in the program-specific reimbursement methodology rules.

(C) Unrestricted grants, gifts, and income from endowments from private sources used to purchase allowable program items should not be offset by the contracted provider prior to reporting on the cost report. All unrestricted funds which are properly allocable to the cost report should be reported on a contracted provider's cost report, as well as any allowable costs to which the unrestricted funds were applied.

(D) Nonroutine revenues such as income from operations not associated with providing contracted services, including, but not limited to, beauty and barber shops, vending machines, gift shops, canteen stores, and meals sold to employees or guests should be offset or reduced by the related expenses prior to reporting the revenue on the cost report. Expenses related to providing these types of non-contracted operations are unallowable costs. If nonroutine operating expenses, including overhead costs incurred to generate nonroutine operating revenue, exceed nonroutine operating revenues, the net nonroutine operating expenses are unallowable costs. Routine operating revenue received as payments for the contracted services, such as income from private clients, private room and board, or other sources of routine contracted services are not to be offset. Refer to §20.102(k) of this title (relating to General Principles of Allowable and Unallowable Costs) for further guidelines on reporting net expenses.

(16) In-kind donations.

(A) Allowable in-kind donations.

(i) Depreciation of in-kind donations is limited to donated buildings and donated vehicles used in the direct provision of contracted client services, where title has been transferred to the provider entity by a third party in an arm's-length transaction. Depreciation must be reported in accordance with paragraph (7) of this subsection. The historical cost basis used to depreciate vehicles must be consistent with the retail price of the National Automobile Dealers Association (NADA) listings; or, in the case of a new vehicle, the documented historical cost to the donor or NADA may be used. The historical cost basis used to depreciate donated buildings must be the lower of:

(I) the most recent tax appraisal of the building prior to donation, unless the donor was exempt from tax appraisal, in which case an independent appraisal made by a third-party appraiser at the time of donation may be used in place of the tax appraisal (for donations made prior to the provider's 1996 fiscal year, a current appraisal from an independent third-party appraiser may be used to establish the historical cost); or

(II) the documented historical cost to the donor.

(ii) Expenses actually incurred to maintain a donated asset for use in providing contracted client care to DHS clients are allowable.

(iii) If a provider receives a donation of the use of space owned by another organization and if the provider and the donor organization are both part of a larger organizational entity (such as units of a state or county government), the space is not considered a related-party donation, but rather treated as allowable costs requiring allocation between the provider and the other organization. For example, if a county home health agency is given space to use in the county office building, costs associated with the use of the space (such as depreciation, janitorial services, maintenance, and repairs) must be allocated from the county to the county home health agency. Allocation of costs must be in compliance with §20.102(j) of this title (relating to General Principles of Allowable and Unallowable Costs).

(B) Unallowable in-kind donations. The value of unallowable in-kind donations may be collected for specific programs at the discretion of DHS for statistical purposes only, on a schedule separately identified for such purpose. The value of in-kind donations to a contracted provider, such as produce, supplies, materials, services, equipment, or other items used by the contracted provider which the contracted provider did not purchase, is an unallowable cost. The value of in-kind donations of buildings or vehicles when the title is not transferred to the provider is an unallowable cost. The value of in-kind donations to a contracted provider which are not arm's-length transactions are unallowable costs. The contracted provider may not treat as an allowable cost the imputed value for unallowable in-kind donations.

(17) Miscellaneous costs.

(A) Employee relations expenses. Costs relating to employee relations are different from fringe benefits, as specified in paragraph (1)(A)(iii) of this subsection, in that employee relations expenses incurred are for employees as a group rather than as a fringe benefit for an individual employee. Examples of allowable employee relations costs, which are reported as administrative costs for cost-reporting purposes, include a staff party, an employee outing, or other such staff expenses intended to boost employee morale and in

turn increase the efficiency and quality of care provided. Other examples of allowable employee relations expenses are plaques or awards presented to employees for certain achievements or honors. Employee relations cost which discriminates in favor of certain employees, such as employees who are officers, stockholders, related parties, or the highest paid individual(s) in the organization are unallowable. Employee relations costs are limited to a ceiling of $50 per employee eligible to participate per year. If a staff party includes nonemployees, an allocation must be made such that only the portion of costs relating to employees and their families in attendance is reported on the cost report. If a staff party also serves as an open house for promotional purposes, an allocation of costs must be made so that only costs relating to employees and their families in attendance are reported as allowable costs. Entertainment expenses other than those for the benefit of current clients or those for staff employee relations described above are unallowable costs

(B) Organization costs. Organization costs are those costs directly incident to the creation of a corporation or other form of business necessary to provide contracted services. These costs are intangible assets in that they represent expenditures for rights and privileges which have a value to the business enterprise.

(i) Allowable organization costs include, but are not limited to, legal fees incurred (such as drafting documents) in establishing the corporation or other organization, necessary accounting fees, and fees paid to states for incorporation. Allowable organization costs must be amortized over a period of not less than 60 consecutive months, beginning with the first month in which services are delivered to the first client.

(ii) The following types of costs are considered unallowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, reorganization costs, and stockholder servicing costs. If the business or corporation never commences actual operations, the organization costs are unallowable.

(C) Franchise fees

(i) Allowable franchise fees. Allowable franchise fees include those costs related to actual goods, supplies, and services received in return for fees paid to a company for the right to sell its goods and/or services in a specific territory.

(ii) Unallowable franchise fees. Franchise fees based upon percentages of revenues and/or sales are unallowable costs. Franchise fees based upon goodwill are unallowable, with goodwill being that intangible, salable asset arising from the reputation of a business and its relationship with its customers.

(D) Startup costs. 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 in paragraph (7) of this subsection. Any costs that are properly identifiable as organization costs or capitalizable as 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 or corporation never commences actual operations or if the new contract/program never delivers services, the startup costs are unallowable.

(i) For a newly-formed business, startup costs should be accumulated up to the time the business begins (that is, when services are delivered to the first client/customer). Amortization of startup costs for a newly-formed business begins the month the business begins. In the event that a newly-formed business is established for the direct purpose of contracting with the State for delivery of client care services, startup costs should be accumulated up to the time the contract is effective or the time the first client receives services, whichever comes first, with amortization of startup costs beginning the same month.

(ii) For a new contract or program implemented by an existing business, startup costs are related only to the development of the provider's ability to furnish services according to the standards of the new contract/program and should be accumulated up to the time the first client receives services according to the contract/program standards or the effective date of the contract, whichever occurs first. Amortization of startup costs for a new contract/program implemented by an existing business begins the month in which the first client receives services according to contract/program standards or the effective date of the contract, whichever occurs first. If a contracted provider intends to prepare all portions of its entire program at the same time, startup costs for all portions of the program should be accumulated in a single account and should be amortized beginning either when the first client is admitted or the effective date of the contract, whichever occurs first. However, if a contracted provider intends to prepare portions of its program on a piecemeal basis, startup costs should be capitalized and amortized separately for the portion(s) of the provider's program prepared during different time periods. For example, a newly-formed corporation opens a senior citizen center for private clients, serving its first client on April 4, 1995. Startup costs would be those costs incurred prior to April 4, 1995, which meet the above definition of startup costs. Amortization of the startup costs for this newly-formed business would begin April 1995. If this same corporation received a contract with DHS to provide Day Activity and Health Services (DAHS) effective October 1, 1995 and if the corporation served its first DAHS client on November 5, 1995, startup costs would be those costs incurred to be able to deliver services according to DAHS program standards. If the corporation was in compliance with the DAHS standards from its beginning (April 1995), no new startup costs would be allowable for amortization as a result of the implementation of the new DAHS contract by the existing corporation. On the other hand, if the corporation was required to incur additional costs to bring the operation up to the DAHS program standards, those startup costs incurred prior to October 1, 1995 (since the contract effective date occurred prior to serving the first DAHS client) would be amortized beginning with October 1995.

(E) Research and development costs. Research and development costs, including, but not limited to, telephone costs, travel costs, attorney fees, and staff salaries, must be segregated into separate, individual accounts for each venture in the contracted provider's general ledger. Should such a "venture" result in a contract for a program, the allowable research and development costs would be incorporated as startup costs for that program. Research and development costs related to states other than Texas are not allowable costs for any allocation to any contracted program.

(F) Medical supplies and medical costs. In general, medical supplies and equipment required by the Occupational Safety and Health Administration (OSHA), used for universal health and safety precautions, or otherwise required to meet contracted program requirements are allowable costs. Refer to program-specific reimbursement methodology rules to determine program requirements for medical supplies and medical costs.

(G) Fines and penalties. Fines and penalties for violations of regulations, statutes, and ordinances of all types are unallowable costs. Penalties or charges for late payment of taxes, utilities, mortgages, loans or insufficient banking funds are unallowable costs

(H) Business expenses not directly related to contracted services. Business expenses not directly related to contracted services, including business investment activities, stockholder and public relations activities, and farm and ranch operations (unless farm and ranch operations are specifically allowed by the contracted program as necessary to the provision of client care), are unallowable costs.

(I) Litigation expenses and awards Unless explicitly allowed elsewhere in this chapter, no court-ordered award of damages or settlements made in lieu thereof or legal fees associated with litigation which resulted in any court-ordered award of damages or settlements made in lieu thereof, or a criminal conviction, are allowable.

(J) Lobbying costs. Lobbying costs are unallowable.

(i) Lobbying means the influencing or attempting to influence an officer or employee of any governmental agency, an officer or employee of Congress or State Legislature, or an employee of a Member of Congress or State Legislature in connection with any of the following actions:

(I) the awarding of any governmental contract;

(II) the making of any governmental grant;

(III) the making of any governmental loan;

(IV) the entering of any cooperative agreement; and

(V) the extension, continuation, renewal, amendment, or modification of any governmental contract, grant, loan or cooperative agreement.

(ii) Costs associated with the following activities are unallowable as lobbying costs:

(I) attempting to influence the outcomes of any governmental election, referendum, initiative, or similar procedure, through in-kind or cash contributions, endorsements, publicity, or similar activity;

(II) establishing, administering, contributing to, or paying the expenses of a political party, campaign, political action committee, or other organization established for the purpose of influencing the outcomes of elections;

(III) attempting to influence the introduction of governmental legislation, the enactment or modification of any pending governmental legislation through communication with any member or employee of the Congress or State Legislature (including efforts to influence state or local officials to engage in similar lobbying activity) or any governmental official or employee in connection with a decision to sign or veto enrolled legislation;

(IV) attempting to influence the introduction of governmental legislation, or the enactment or modification of any pending governmental legislation by preparing, distributing or using publicity or propaganda, or by urging members of the general public, or any segment thereof, to contribute to or participate in any mass demonstration, march, rally, fund raising drive, lobbying campaign or letter writing or telephone campaign; and

(V) performing legislative liaison activities, including attendance at legislative sessions or committee hearings, gathering information regarding legislation, and analyzing the effect of legislation, when such activities are carried on in support of or in knowing preparation for an effort to engage in unallowable lobbying.

(iii) The cost to contracted providers or their staff to attend meetings with the staff of state agencies or to attend public hearings or advisory committee meetings held by state agencies which are involved in the regulation of contracted client care in the program which they are contracting and which meetings do not meet the definition of lobbying stated above, are not considered lobbying and are therefore allowable costs.

(iv) Expenses relating to lobbying are unallowable including salaries, benefits, and payroll taxes for staff performing these activities. If a staff member performs these activities along with allowable activities, a portion of that staff member's salary must be allocated to the unallowable activities and as such not be reported on the cost report.

(K) Direct reimbursements. Any expenses directly reimbursable to the contracted provider which are considered outside the reimbursement payment system are unallowable costs, including, but not limited to, costs associated with Medicare Part A and B ancillary services. For guidelines on allowability of reporting costs in excess of those reimbursable directly through a voucher payment system, refer to program-specific reimbursement methodology rules

(L) Losses resulting from theft or embezzlement. Losses resulting from theft or embezzlement of property or funds of clients held in trust by the contracted provider are not allowable costs.

(M) A bad debt. A bad debt allowance is a reduction in revenue resulting from unrecoverable revenue in uncollectible accounts created or acquired in the provision of contracted client care. Bad debt as an expense is unallowable.

(N) A charity or courtesy allowance. A charity allowance is a reduction in normal charges due to the indigence of the client or resident. A courtesy allowance is a reduction in charges granted as a courtesy to certain individuals, such as physicians or clergy. These allowances themselves are not costs since the costs of the services rendered are already included in the contracted provider's costs.

(18) Medicaid as payor of last resort. Medicaid is the payor of last resort. Costs for which a recipient had Medicare Part A or B benefits, third party payor benefits, vendor drug coverage, or any other benefits available are not allowable unless the provider can document that a provider of services was not accessible. At a minimum, the documentation must include a list of the providers contacted, dates(s) of contact, person to whom spoken, telephone number, and reason given for rejection. It is the availability of these benefits to cover the cost, not their utilization, which defines the cost as unallowable.

*§20.104 Revenues.* A provider must report revenues that reflect the activity of the provider and that are directly related to the provision of contracted client care or services. A provider may not report revenues from other programs or activities in which the contracted provider may be engaged.

(1) Revenues should be reported net of charity allowances and courtesy allowances, and bad debt expense.

(2) Any revenues received directly by the provider through a voucher must not be reported on the cost report.

Revenues received by the provider from other direct payment systems must not be reported on the cost report unless specifically requested by the program-specific reimbursement methodology rules or cost report instructions.

(3) For guidelines in reporting revenue received as a federal grant, refer to §20.103(b)(15) of this title (relating to Specifications for Allowable and Unallowable Costs) and to program-specific reimbursement methodology rules.

(4) For guidelines in offsetting certain expenses against operating revenues, refer to §20.103(b)(15)(D) of this title (relating to Specifications for Allowable and Unallowable Costs). Interest expenses should be offset against interest income prior to reporting net interest expense or net interest income.

*§20.105. General Reporting and Documentation Requirements, Methods, and Procedures*

(a) General reporting. Except where otherwise specified under this title, the Texas Department of Human Services (DHS) follows the requirements, methods, and procedures set forth in subsections (b)-(g) of this section to determine costs appropriate for use in the reimbursement determination process

(b) Cost report requirements. Unless specifically stated in program rules, each provider must submit financial and statistical information on cost report forms provided by DHS, or on facsimiles which are formatted according to DHS specifications and are pre-approved by DHS staff, or electronically in DHS-prescribed format in programs where these systems are operational. The cost reports must be submitted to DHS in a manner prescribed by DHS. The cost reports must be prepared to reflect the activities of the provider during the fiscal year specified by the cost report. Cost reports or other special surveys or reports may be required for other periods at the discretion of DHS. Each provider is responsible for accurately completing any cost report or other special survey or report submitted to DHS.

(1) Accounting methods. All financial and statistical information submitted on cost reports must be based upon the accrual method of accounting, except where otherwise specified in §20.102 and §20.103 of this title (relating to General Principles of Allowable and Unallowable Costs, and Specifications for Allowable and Unallowable Costs) and in the case of governmental entities operating on a cash or modified accrual basis. For cost-reporting purposes, accrued expenses must be incurred during the cost reporting period and must be paid within 180 days after the end of that cost reporting period. Accrued revenues must be for services performed during the cost reporting period and do not have to be received within 180 days after the end of that cost reporting period in order to be reported as revenues for cost-reporting purposes. Except as otherwise specified by the cost determination process rules of this chapter, cost report instructions, or policy clarifications, cost reports should be prepared consistent with generally accepted accounting principles (GAAP), which are those principles approved by the American Institute of Certified Public Accountants (AICPA). Internal Revenue Service (IRS) laws and regulations do not necessarily apply in the preparation of the cost report. In cases where cost reporting rules differ from GAAP, IRS, or other authorities, DHS rules take precedence for provider cost-reporting purposes.

(2) Recordkeeping and adequate documentation. There is a distinction between noncompliance in recordkeeping, which equates with unauditability of a cost report and constitutes an administrative contract violation, and a provider's inability to provide adequate documentation, which results in disallowance of relevant costs. Each is discussed in the following paragraphs.

(A) Recordkeeping. Each provider must maintain records according to the requirements stated in §69.205 of this title (relating to Contractor's Records) and according to DHS's prescribed chart of accounts, when available. Providers must ensure that records are accurate and sufficiently detailed to support the legal, financial, and other statistical information contained in the cost report. Failure to maintain all workpapers and any other records that support the information submitted on the cost report relating to all allocations, cost centers, cost or statistical line items, surveys, and schedules constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §19.2609 of this title (relating to Vendor Hold) for nursing facilities or §20.111 of this title (relating to Administrative Contract Violations) for all other programs.

(B) Adequate documentation. To be allowable, the relationship between reported costs and contracted services must be clearly and adequately documented. Adequate documentation consists of all materials necessary to demonstrate the relationship of personnel, supplies, and services to the provision of contracted client care or the relationship of the central office to the individual service delivery entity level. These materials may include, but are not limited to, accounting records, invoices, organizational charts, functional job descriptions, other written statements, and direct interviews with staff, as deemed necessary by DHS auditors to perform required tests of reasonableness, necessity, and allowability. For the 1996 cost report only, DHS will accept documentation to retrospectively support expenses which were incurred in the provider's 1996 fiscal year prior to the adoption of these rules and reported on the provider's 1996 cost report. This supportive documentation must not be dated later than June 30, 1996.

(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 during seven continuous days The timestudy can be performed for one continuous week during a quarter, or it can be performed over 5 or 7 individual days, whichever is applicable, throughout a quarter. The time study must be a 100% time study, accounting for 100% of the time paid the employee, including vacation and sick leave

(ii) To support the existence of a loan, the provider must have available a signed copy of the loan contract which contains the pertinent terms of the loan, such as amount, rate of interest, method of payment, due date, and collateral. The documentation must include an explanation for the purpose of the loan and an audit trail must be provided showing the use of the loan proceeds. Evidence of systematic interest and principal payments must be available and supported by the payback schedule in the note or amortization schedule supporting the note. Documentation must also include substantiation of any costs associated with the securing of the loan, such as broker's fees, due diligence fees, lender's fees, attorney's fees, etc. To document allowable interest costs associated with related party loans, the provider is required to maintain documentation verifying the prime interest rate in accordance with §20.103(b)(8)(C) of this title (relating to Specifications for Allowable and Unallowable Costs) for a similar type of loan as of the effective date of the related party loan.

(iii) For transportation equipment, a mileage log is not required if the equipment is used solely (100%) for provision of contracted client services in accordance with program requirements in delivering one type of contracted care. However, the contracted provider must have a written policy which states that the equipment is restricted to that use and that policy

must be followed. For transportation equipment that is used for several purposes (including for personal use) or multiple programs or across various business components, mileage logs must be maintained. Personal use includes, among other things, driving to and from a personal residence At a minimum, mileage logs must include for each individual trip the date, the time of day (beginning and ending), driver, persons in the vehicle, trip mileage (beginning, ending, and total), purpose of the trip, and the allocation centers (the departments, programs, and/or business entities to which the trip costs should be allocated). Flight logs must include dates, mileage, passenger lists, and destinations, along with any other information demonstrating the purpose of the trips so that a relationship to contracted client care in Texas can be determined Documentation substantiating that private aircraft travel expenses are not greater than ground transportation or commercial alternatives includes written documentation to support calculations of mileage reimbursement, staff per diem costs, staff salary costs for time during the trip and at the terminal/station, rental car costs, commercial airplane fare, and any other costs associated with the ground transportation/commercial alternatives

(iv) To substantiate the allowable cost of leasing a luxury vehicle as defined in §20.103(b)(7)(C)(i) of this title (relating to Specifications for Allowable and Unallowable Costs), the provider must obtain at the time of the lease a separate quotation establishing the monthly lease costs for the base amount allowable for cost-reporting purposes as specified in §20.103(b) (7)(C)(i) of this title (relating to Specifications for Allowable and Unallowable Costs). If the lease of the luxury vehicle occurred prior to January 1, 1996, then the provider must obtain the separate quotation prior to submitting its 1996 cost report in order for the allowable costs to be reported on the cost report. Without adequate documentation to verify the allowable lease costs of the luxury vehicle, the reported costs shall be disallowed.

(v) For adequate documentation purposes, a written description of each cost allocation method must be maintained which includes, at a minimum, a clear and understandable explanation of the numerator and denominator of the allocation ratio described in words and in numbers, as well as a written explanation of how and to which specific business components the remaining percentage of costs were allocated.

(vi) To substantiate the allowable cost for staff training as defined in §20.103(b)(12)(A) of this title (relating to Specifications for Allowable and Unallowable Costs), the provider must maintain a description of the training verifying that the training pertained to contracted client care-related services or quality assurance At a minimum, a program brochure describing the seminar or a conference program with description of the workshop must be maintained The documentation must provide a description clearly demonstrating that the seminar or workshop provided training pertaining to contracted client care-related services or quality assurance.

(vii) Documentation regarding the allocation of costs related to noncontracted services, as specified in §20.102(j)(2) of this title (relating to General Principles of Allowable and Unallowable Costs), must be maintained by the provider. At a minimum, the provider must maintain written records verifying the number of units of noncontracted services provided during the provider's fiscal year, along with adequate documentation supporting the direct and allocated costs associated with those noncontracted services.

(viii) Adequate documentation to substantiate legal, accounting, and auditing fees must include, at a minimum, the amount of time spent on the activity, a written description of the activity performed which clearly explains to which business component the cost should be allocated, the person performing the activity, and the hourly billing amount of the person performing the activity. Other legal, accounting, and auditing costs, such as photocopy costs, telephone costs, court costs, mailing costs, expert witness costs, travel costs, and court reporter costs, must be itemized and clearly denote to which business component the cost should be allocated

(ix) Providers who self insure for all or part of their employee-related insurance costs, such as health insurance and workers' compensation costs, must use one of the two following methods for determining and documenting the provider's allowable costs under the cost ceilings and any carry forward as described in §20.103(b)(10)(E) of this title (relating to Specifications for Allowable and Unallowable Costs).

(I) Providers may obtain and maintain each fiscal year's documentation to establish what their premium costs would have been had they purchased commercial insurance for total coverage. The documentation should include, at a minimum, bids from two commercial carriers. Bids must be obtained no less frequently than every three years.

(II) If providers choose not to obtain and maintain commercial bids as described in subclause (I) of this clause, providers may claim as an allowable cost the health insurance actual paid claims incurred on behalf of the employees that does not exceed 10% of the payroll for employees eligible for receipt of this benefit In addition, providers may claim as an allowable cost the workers' compensation actual paid claims incurred on behalf of the employees, an amount each cost report period not to exceed 10% of the payroll for employees eligible for receipt of this benefit

(III) Providers who self insure must also maintain documentation that supports the amount of claims paid each year and any allowable costs to be carried forward to future cost-reporting periods.

(x) Providers who self insure for all or part of their coverage for non-employee-related insurance, such as malpractice insurance, comprehensive general liability, and property insurance, must maintain documentation for each cost-reporting period to establish what their premium costs would have been had they purchased commercial insurance for total coverage. The documentation should include, at a minimum, bids from two commercial carriers. Bids must be obtained no less frequently than every three years Providers who self insure must also maintain documentation that supports the amount of claims paid each year and any allowable costs to be carried forward to future cost-reporting periods. Governmental providers must document the existence of their claims management and risk management programs

(xi) Regarding compensation of owners and related parties, providers must maintain the following documentation, at a minimum, for each owner or related party: a detailed written description of actual duties, functions, and responsibilities; documentation substantiating that the services performed are not duplicative of services performed by other employees; time sheets or other documentation verifying the hours and days worked; the amount of total compensation paid for these duties, with a breakdown detailing regular salary, overtime, bonuses, fringe 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; and a detailed allocation worksheet indicating how the total compensation was allocated across business components receiving the benefit of these duties.

(I) Regarding bonuses paid to owners and related parties, the provider must maintain clearly defined bonus policies in its written agreements with employees or in its overall employment policy.

At a minimum, the documentation must include the basis for distributing the bonuses, how the amount of each bonus is calculated, who received bonuses, whether the persons receiving bonuses are owners, related parties, or arm's-length employees, and the bonus amount received by each individual.

(II) Regarding fringe benefits provided to owners and related parties, the provider must maintain clearly defined benefit policies in its written agreements with employees or in its overall employment policy. At a minimum, the documentation must include the basis for eligibility for each type of fringe benefit available, who is eligible to receive each type of fringe benefit, who actually receives each type of fringe benefit, whether the persons receiving each type of benefit are owners, related parties, or arm's-length employees, and the amount of each fringe benefit received by each individual.

(xii) Regarding all forms of compensation, providers must maintain documentation for each employee which clearly identifies each compensation component, including regular pay, overtime pay, incentive pay, mileage reimbursements, bonuses, sick leave, vacation, other paid leave, deferred compensation, retirement contributions, provider-paid instructional courses, health insurance, disability insurance, life insurance, and any other form of compensation. Types of documentation would include insurance policies; provider benefit policies; records showing paid leave accrued and taken; documentation to support hours (regular and overtime) worked and wages paid; and mileage logs or other documentation to support mileage reimbursements and travel allowances. For accrued fringe benefits, the documentation must clearly identify the period of the accrual. For example, if an employee accrues two weeks of vacation during 19x1 and receives the corresponding vacation pay during 19x3, that employee's compensation documentation for 19x3 should clearly indicate that the vacation pay received had been accrued during 19x1.

(xiii) Management fees paid to related parties must be documented as to the actual costs of the related party for materials, supplies, and services provided to the individual provider, and upon which the management fees were based. If the cost to the related party includes owner compensation or compensation to related parties, documentation guidelines for those costs are specified in clause (xi) of this subparagraph. Documentation must be maintained that indicates stated objectives, periodic assessment of those objectives, and evaluation of the progress toward those objectives.

(xiv) For central office and/or home office costs, documentation must be maintained that indicates the organization of the business entity, including position, titles, functions, and compensation. For multi-state organizations, documentation must be maintained that clearly defines the relationship of costs associated with any level of management above the individual Texas contracted entity which are allocated to the individual Texas contracted entity.

(xv) Documentation regarding depreciable assets includes, at a minimum, historical cost, date of purchase, depreciable basis, estimated useful life, accumulated depreciation, and the calculation of gains and losses upon disposal.

(xvi) Providers must maintain documentation clearly itemizing their employee relations expenditures. For employee entertainment expenses, documentation must show the names of all persons participating, along with classification of the person attending, such as employee, nonemployee, owner, family of employee, client, or vendor.

(xvii) Adequate documentation substantiating the offsetting of grants and contracts from federal, state, or local governments prior to reporting either the net expenses or net revenue must be maintained by the provider. As specified in §20.103(b)(15) of this title (relating to Specifications for Allowable and Unallowable Costs), such offsetting is required prior to reporting on the cost report. The provider must maintain written documentation as to the purpose for which the restricted revenue was received and the offsetting of the restricted revenue against the allowable and unallowable costs for which the restricted revenue was used

(xviii) During the course of an audit or an audit desk review, the provider must furnish any reasonable documentation requested by DHS auditors within ten working days of the request or a later date as specified by the auditors. If the provider does not present the requested material within the specified time, the audit or audit desk review is closed, and DHS automatically disallows the costs in question.

(xix) Any expense which cannot be adequately documented or substantiated is disallowed. DHS is not responsible for the contracted provider's failure to adequately document and substantiate reported costs.

(xx) Any cost report which is determined unauditable through a field audit or which cannot have its costs verified through a desk review will not be used in the reimbursement determination process.

(3) Cost report and methodology certification. Providers must certify the accuracy of cost reports submitted to DHS in the format specified by DHS Providers may be liable for civil and/or criminal penalties if the cost report is not completed according to DHS requirements or is determined to contain misrepresented or falsified information. Cost report preparers must certify that they received reimbursement methodology rules regarding allowable and unallowable costs, that they read the reimbursement methodology and cost report instructions, and that they understand that the cost report must be prepared in accordance with the methodology rules and cost report instructions. Not all persons who contributed to the completion of the cost report must sign the certification page. However, the certification page must be signed by a responsible party with direct knowledge of the preparation of the cost report. 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

(4) Requirements for Cost Report Completion

(A) A completed cost report must

(i) be completed according to the cost determination rules of this chapter, program-specific allowable and unallowable rules, cost report instructions, and policy clarifications,

(ii) contain a signed, notarized, original certification page;

(iii) be legible with entries in sufficiently dark print to be photocopied;

(iv) contain all pages and schedules;

(v) be submitted on the proper cost report form;

(vi) be completed using the correct cost reporting period; and

(vii) contain a copy of the state-issued cost report training certificate, beginning with the 1996 cost report.

(B) Providers are required to report amounts on the appropriate line items of the cost report pursuant to guidelines established in the methodology rules, cost report instructions, and/or policy clarifications. Placement on the cost report of an amount which was determined to be inaccurately placed constitutes an administrative contract violation. Refer to program-specific reimbursement methodology rules, cost report instructions, and/or policy clarifications for guidelines used to determine placement of amounts on cost report line items. In the case of an administrative con-

tract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §19.2609 of this title (relating to Vendor Hold) for nursing facilities or §20.111 (Administrative Contract Violations) for all other programs.

(C) Failure to file a completed cost report by the cost report due date constitutes an administrative contract violation. In the case of a contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §19.2609 of this title (relating to Vendor Hold) for nursing facilities or §20.111 of this title (relating to Administrative Contract Violations) for all other programs.

(D) DHS may excuse providers from the requirement to submit a cost report. Exceptions are granted by DHS as described by the program-specific reimbursement methodology rules. Providers who are excused from cost report submission will receive written notice from DHS verifying that an exception has been granted.

(5) Cost report year. A provider's cost report year must coincide with the provider's fiscal year as used by the provider for reports to the Internal Revenue Service (IRS). Providers are responsible for reporting to DHS any change in their IRS fiscal year and subsequent cost report year by submitting written notification of the change to DHS along with supportive IRS documentation. DHS must be notified of the provider's change in IRS fiscal year no later than 30 days following the provider's receipt of approval of the change from the IRS.

(6) Failure to report allowable costs. DHS is not responsible for the contracted provider's failure to report allowable costs, however any omitted costs which are identified during the desk review or audit process will be included in the cost report or brought to the attention of the provider to correct by submitting an amended cost report.

(c) Cost report due date.

(1) Providers must submit cost reports to DHS no later than 90 days following the end of the provider entity's fiscal year or 90 days from the transmittal date of the cost report forms, whichever due date is later.

(2) DHS may grant extensions of due dates for good cause. A good cause is defined as a circumstance which the provider could not reasonably be expected to control and for which adequate advance planning and organization would not have been of any assistance. Providers must submit requests for extensions in writing to DHS. Requests for extensions must be received by DHS prior to the cost report due date. DHS staff will respond in writing to requests within 15 days of receipt.

(3) DHS may require additional financial and other statistical information, in the form of special surveys or reports, to ensure the fiscal integrity of the program. Providers must submit such additional information and/or special surveys or reports to DHS upon request by the date specified by DHS in its transmittal or cover letter to the special survey, report, or request for additional information.

(d) Amended cost report due dates. DHS accepts submittal of provider-initiated or DHS-requested amended cost reports as follows.

(1) Provider-initiated amended cost reports must be received no later than the date in subparagraph (A) or (B) of this paragraph, whichever occurs first. Amended cost reports received after the required date have no effect on the reimbursement determination. Amended cost report information that cannot be verified will not be used in reimbursement determinations. Provider-initiated amended cost reports must be received no later than the earlier of:

(A) 60 days after the original due date of the cost report, or

(B) for Medicaid programs, 30 days prior to the public hearing on proposed reimbursement or reimbursement parameter amounts; and for non-Medicaid programs 45 days, prior to the DHS board meeting to approve reimbursement or reimbursement parameter amounts.

(2) DHS-required amendments to the cost reports must be received on or before the date specified by the DHS in its request for the amended cost report. 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 subsection (b)(4)(C) of this section.

(e) Field audit standards. DHS performs cost report field audits in a manner consistent with Government Auditing Standards issued by the Comptroller General of the United States.

(f) Cost of out-of-state audits. As specified in §20.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), DHS conducts desk reviews of all cost reports not selected for field audit. DHS also conducts field audits of provider records and cost reports. Although the number of field audits performed each year may vary, DHS seeks to maximize the number of field audited cost reports available for use in its cost projections. Whenever possible, the records necessary to verify information submitted to DHS on cost reports, including related party transactions and other business activities engaged in by the provider, must be accessible to DHS audit staff within the State of Texas. When records are not available to DHS audit staff within the State of Texas, the provider must pay the actual costs for DHS staff to travel and review the records out-of-state. Failure to reimburse DHS for these costs within 60 days of the request for payment constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §19.2609 of this title (relating to Vendor Hold) for nursing facilities or §20.111 of this title (relating to Administrative Contract Violations) for all other programs.

(g) Public hearings.

(1) Uniform reimbursements. For Medicaid programs where reimbursements are uniform by class of service and/or provider type, DHS will hold a public hearing on proposed reimbursements before the Texas Board of Human Services (board) approves reimbursements. The purpose of the hearing is to give interested parties an opportunity to comment on DHS's proposed reimbursements. Notice of the hearing will be provided to the public. The notice of the public hearing will identify the name, address, and telephone number to contact for the materials pertinent to the proposed reimbursements. At least ten working days before the public hearing takes place, material pertinent to the proposed statewide uniform Medicaid reimbursements will be made available to the public. This material will include the proposed reimbursements, the inflation adjustments used to determine them, and the impact on reimbursements of the major cost limits. This material will be furnished to anyone who requests it. After the public hearing, if negative comments are received, a written summary of the comments made during the public hearing will be presented to the board.

(2) Contractor-specific reimbursements. In programs where reimbursements are contractor-specific, DHS will hold a public hearing on the reimbursement determination parameter dollar amounts (e.g., ceilings, floors, or program reimbursement formula limits) before the board approves parameter dollar amounts. The purpose of the hearing is to give interested parties an opportunity to comment on DHS's proposed reimbursement parameter dollar amounts. Notice of the hearing will be provided to the public. The notice of the public hearing will identify the name, address, and telephone number to contact for the materials pertinent to the proposed reimbursement parameter dollar amounts. At

least ten working days before the public hearing takes place, material pertinent to the proposed reimbursement parameter dollar amounts will be made available to the public. This material will include the proposed reimbursement parameter dollar amounts, the inflation adjustments used to determine them, and the impact on the reimbursement parameter dollar amounts of the major cost limits. This material will be furnished to anyone who requests it. After the public hearing, if negative comments are received, a written summary of the comments made during the public hearing will be presented to the board.

(h) When insufficient cost data are available. If an insufficient number of accurate, full-year cost reports is submitted, as would occur with a new program, or if there are insufficient available data, as would occur in changes in program design, changes in the definition of units of service or changes in regulations or program requirements, reimbursements may be based on a pro-forma analysis by DHS staff. A pro-forma analysis is defined as an item-by-item, or classes-of-items, calculation of the reasonable and necessary expenses for a provider to operate. The analysis may involve assumptions about the salary of an administrator or program director, staff salaries, employee benefits and payroll taxes, building depreciation, mortgage interest, contracted client care expenses, and other building or administration expenses. To determine the cost per unit of service, DHS adds all the pro-forma expenses and divides the total by the estimated number of units of service that a fully operational provider is likely to provide. The pro-forma analysis is based on available information that is determined to be sufficient, accurate, and reliable by DHS, including valid cost report data and survey data. The pro-forma analysis is conducted in a way that ensures that the resultant reimbursements are sufficient to support the requirements of the contracted program. When DHS staff determine that sufficient and reliable cost report data have become available, the pro-forma reimbursement determination may be replaced with a process based on cost reports.

*§20.106. Basic Objectives and Criteria for Audit and Desk Review of Cost Reports.*

(a) The Texas Department of Human Services (DHS) conducts desk reviews and field audits of provider cost reports in order to ensure that all financial and statistical information reported in the cost reports conforms to all applicable rules and instructions. Cost reports not completed according to instructions or rules in accordance with §20.105(b)(4) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures) constitutes a contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §19.2609 of this title (relating to Vendor Hold) for nursing facilities or §20.111 of this title (relating to Administrative Contract Violations) for all other programs DHS may require supporting documentation other than that contained in the cost report to substantiate reported information.

(b) The basic objective of audits and desk reviews is to verify that each provider's cost report:

(1) displays financial and other statistical information in the format required by DHS;

(2) reports expenses in conformity with DHS's lists of allowable and unallowable costs;

(3) follows generally accepted accounting principles, except as otherwise specified in DHS'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

(4) is completed in accordance with each program's cost report instructions and rules.

(c) DHS verifies the information specified in subsection (b) of this section by:

(1) comparing each provider's reported costs to:

(A) past patterns of expenditures for similar services;

(B) the results of previous field audits;

(C) normal operating cost relationships; and

(D) industry average costs, when available;

(2) reviewing each provider's reported costs for:

(A) reported unallowable costs;

(B) omitted allowable costs, if discovered during the course of the audit or desk review; and

(C) understated or overstated allowable costs, if discovered during the course of the audit or desk review;

(3) checking for completion of required information;

(4) checking the format for proper cost classification;

(5) checking for mathematical accuracy; and

(6) adjusting the cost report, or notifying the provider that research and/or corrections are required.

(d) In accordance with methodology rules, cost report instructions or policy clarifications, DHS may reassign allowable costs to the appropriate line items of a cost report

(e) DHS seeks to maximize the number of field audited cost reports available for use in its cost projections. In addition to cost reports selected for field audit based upon risk analysis, other specific criteria and random sampling, DHS may conduct field audits of cost reports that show unusual fluctuations or trends in costs or other statistics. DHS may also conduct field audits when desk reviews are insufficient to verify the accuracy of reported costs.

(f) Each provider entity or its designated agent(s) must allow access to any and all records necessary to verify information submitted to DHS on cost reports. This requirement includes records pertaining to related party transactions or other business activities engaged in by the provider. Failure to allow access to records constitutes a contract violation. In the case of a contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §19.2609 of this title (relating to Vendor Hold) for nursing facilities or §20.111 of this title (relating to Administrative Contract Violations) for all other programs.

(g) A contracted provider may request an informal review, and subsequently an appeal, of a desk review or field audit disallowance in accordance with §20.110 of this title (relating to Informal Reviews and Formal Appeals).

*§20.107. Notification of Exclusions and Adjustments.*

(a) The Texas Department of Human Services (DHS) notifies providers of exclusions and adjustments to reported expenses made during DHS's desk reviews and field audits of cost reports. DHS mails notices of desk-review exclusions and adjustments within 15 working days after finalization of the desk-review by DHS auditors. The notice consists of a letter to the provider and desk-review adjustment sheet(s) that specifies:

(1) the line-items on the cost report that have been adjusted or excluded;

(2) the amount of each adjustment or exclusion; and

(3) the principal reason for each adjustment or exclusion.

(b) DHS also furnishes providers with written reports of the results of field audits. DHS mails each field audit report within 30 days after the final exit interview with the provider. An exit interview is final when DHS audit staff have received, reviewed, and analyzed all documentation from the provider pertinent to the scope of the audit. The field audit report consists of a professional report prepared by DHS audit staff to enumerate the results of a field audit. Each field audit report includes a specification of:

(1) cost report line-items that have been adjusted or excluded;

(2) the amount of each adjustment or exclusion; and

(3) the principal reason for each adjustment or exclusion.

(c) DHS mails field audit reports and notices of desk-review exclusions and adjustments to the addresses that providers have given DHS as their standard mailing addresses. However, if a provider submits a written request for DHS to send a field audit report or notice of desk-review exclusions and adjustments to an address other than the provider's standard mailing address, DHS may do so.

(d) A provider may also submit a written request for DHS to provide additional information about exceptions and adjustments to the provider's cost report, including citations of the laws or regulations that constitute the grounds for the exceptions and adjustments. DHS must comply with such requests in writing within 30 calendar days.

*§20.108. Determination of Inflation Indices.*

(a) Function and types of indices. In order to account for cost inflation between the reporting period and the prospective reimbursement period, the Texas Department of Human Services (DHS) makes adjustments to allowable costs based on inflation factors or multipliers calculated from appropriate inflation indices. DHS retains the discretion, on a program by program basis, to exercise the following options in order to obtain appropriate inflation indices.

(b) Contracting for inflation index development. DHS may contract with a reputable and experienced independent professional firm to develop appropriate optional indices for Texas. If DHS obtains such indices under contract, the agency retains the option, on a program by program basis, of utilizing these indices and/or those described in the remainder of this section, either separately or in combination, for reimbursement determination purposes.

(c) Cost inflation indices. DHS may utilize a general cost inflation index obtained from a reputable independent professional source and, where DHS deems appropriate and pertinent data are available, to develop and/or utilize several item-specific and program-specific inflation indices, as follows.

(d) General cost inflation index. DHS uses the Implicit Price Deflator-Personal Consumption Expenditures (IPD-PCE) as the general cost inflation index. The IPD-PCE is a nationally recognized measure of inflation published by the Bureau of Economic Analysis of the U.S. Department of Commerce. To project or inflate costs from the reporting period to the prospective reimbursement period, DHS uses the lowest feasible IPD-PCE forecast consistent with the forecasts of nationally recognized sources available to DHS at the time proposed reimbursement is prepared for public dissemination and comment.

(e) Item-specific and program-specific inflation indices. DHS may use specific indices in place of the general cost inflation index specified in subsection (d) of this section when appropriate item-specific or program-specific cost indices are available from DHS cost reports or other surveys, other Texas state agencies or independent private sources, or nationally recognized public agencies or independent private firms, and DHS has determined that these specific indices are derived from information that adequately represents the program(s) or cost(s) to which the specific index is to be applied. For example, DHS may use specific indices pertaining to cost items such as payroll taxes, key professional and non-professional staff wages, and other costs subject to specific federal or state limits. The specific indices that DHS may use include the following.

(1) Federal Insurance Contributions Act (FICA) or Social Security taxes, including Old Age, Survivors, and Disability Insurance (OASDI) and Medicare taxes, are set by Federal statute. The inflation index for these taxes is the average tax rate, or average tax per payroll dollar, during the prospective reimbursement period divided by the average tax rate, or average tax per payroll dollar, during each provider's reporting period. If tax rates for the prospective reimbursement period are not available at the time proposed reimbursement is prepared for public dissemination and comment, projections are based on the compounded annual rate of change in these tax rates from the most recent consecutive two-year period for which data are available at the time proposed reimbursement is determined.

(2) For providers covered by standard Workers' Compensation Insurance (WCI), the WCI index is based on rate figures by job classification made available by the Texas Department of Insurance. DHS determines which available job classification category most closely tracks WCI costs in each program and calculates a historical WCI inflation index based on the tax rates for each pertinent category. The WCI inflation index is the average insurance rate during the prospective reimbursement period divided by the average insurance rate during each provider's reporting period. If basic insurance rates for the prospective reimbursement period are unknown at the time proposed reimbursement is calculated for public dissemination and comment, projections are based on the compounded annual rate of change in WCI insurance rates from the most recent consecutive two-year period for which data are available at the time reimbursement is calculated. For providers participating in other types of workers' compensation plans deemed allowable under other pertinent sections of DHS rules, the WCI index may be based on projected rates for each provider. Such projections must be developed by independent professional entities and must be based on sound actuarial principles.

(3) Except where indicated otherwise for specific programs, the unemployment tax inflation index is based on unemployment insurance payroll taxes in accordance with the Federal Unemployment Tax Act (FUTA) and the Texas Unemployment Compensation Act (TUCA) rates obtained from the Texas Employment Commission (TEC). Because the TUCA component of the tax rate may be contractor-specific, DHS obtains the average effective rates for the lowest available Standard Industrial Classification (SIC) code pertinent to each program. The unemployment tax inflation index is the average tax rate during the prospective reimbursement period divided by the average tax rate during each provider's reporting period. If the average tax rate for the prospective reimbursement period is unknown at the time proposed reimbursement is calculated for public dissemination and comment, projections are based on the compounded annual rate of change in FUTA/TUCA tax rates from the most recent consecutive two-year period for which data are available at the time reimbursement is calculated. When changes occur in such factors as payroll limits to which tax rates apply, DHS may make appropriate adjustments in projections to reflect new limits and related factors affecting the impact of new limits, such as employee turnover rates.

(4) The unemployment tax inflation index for the Primary Home Care program is based on Texas Employment Commission tax rate notices submitted by providers. To calculate this index, DHS establishes a provider factor by dividing the

present tax rate shown on the TEC tax-rate notice by the tax rate shown on the notice two years previously. These factors are then arrayed in a distribution from lowest to highest. The inflation index is the provider factor from the distribution array that corresponds to the median of accumulated hours of service for all contracted providers.

(5) Inflation factors for professional staff wages and salaries are based on wage and salary survey data pertaining to specific types of professional staff in Texas when reliable data of this kind are available for specific or comparable programs. Projections from the cost reporting period to the reimbursement period are based on discernible trends or experience as evidenced by the most recent reliable data available at the time proposed reimbursement is prepared for public dissemination and comment, and take into consideration economic conditions and regulatory changes which may be reasonably anticipated for the reimbursement period.

(6) When reliable wage and salary data pertaining to specific types of staff in Texas are unavailable for specific or comparable programs, inflation factors for professional staff are based on the lowest feasible forecast of the IPD-PCE. Professional wage and benefit inflation rates for state employees are based on state employee wage and salary increases determined by the Texas Legislature.

(7) Inflation factors for key para-professional staff wages and salaries are based on wage and salary survey data pertaining to specific types of staff in Texas when reliable data are available for specific or comparable programs. Projections from the cost reporting period to the prospective reimbursement period are based on discernible trends or recent experience as evidenced by the most recent data available at the time reimbursement is prepared for public dissemination and comment, and take into consideration economic conditions and regulatory changes which may be reasonably anticipated for the reimbursement period. When reliable wage and salary data pertaining to specific types of staff in Texas are unavailable for specific or comparable programs, inflation factors for key para-professional staff are based on the lowest feasible forecast of the IPD-PCE. Nonprofessional or para-professional wage and benefit inflation rates for state employees are based on state employee wage and salary increases determined by the Texas Legislature.

(8) For the Medicaid nursing facility program, determination of adjustments to historical costs of fixed capital assets are consistent with requirements of the federal Omnibus Budget Reconciliation Act of 1984 (OBRA 1984) and Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 1985). For each program, one of two options is used.

(A) Reimbursement is in the form of a fixed capital asset use fee component of the overall reimbursement, based on facility appraisals, as described in program-specific reimbursement methodology rules.

(B) Reimbursement for fixed capital asset costs is calculated based on historical costs included in the reimbursement component designated in program-specific reimbursement methodology rules. The index used to inflate lease expense and to adjust the allowable depreciation base of assets which have undergone ownership changes is one-half the All-item Urban Consumer Price Index (CPI-U).

*§20.109. Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs.*

(a) The Texas Department of Human Services (DHS) makes interim adjustments to reimbursement when federal or state laws, rules, regulations, policies, or guidelines are adopted, promulgated, judicially interpreted, or otherwise changed in ways that require most if not all providers to take definitive actions that clearly require changes in expenditures on allowable costs which are, on average over the period the reimbursements in question are scheduled to be in effect, in excess of 2.0% of the reimbursement. In programs where reimbursements are uniform by class of service and/or provider type, this 2.0% rule is applied to the amount above the mean, weighted median or median, depending upon which statistic(s) is (are) used to determine reimbursement for each uniform reimbursement class. In programs where reimbursement is contractor-specific, the 2.0% rule is applied on an individual provider basis; however, interim adjustments are limited to those costs at or below the limits defined at the time reimbursement was determined. DHS proposes adjustments to reimbursement for the above reasons at the earliest feasible opportunity to become effective on the effective date of the federal or state laws, rules, regulations, policies, or guidelines or at the beginning of the nearest calendar quarter for which federal financial participation is available.

(b) DHS may also make interim adjustments to reimbursement when it can be clearly demonstrated that changes in economic factors will result, on average over the period the reimbursement in question is scheduled to be in effect, in allowable cost increases for most if not all providers, over which they have little or no control, in excess of two 2.0% of the reimbursement. Such changes in economic factors include, but are not limited to, changes in the rate of wage and price inflation that are not discernible in cost report data or in other data available at the time reimbursement is determined, increases in the number of participating providers or clients with significantly different costs which are demonstrably necessary for provision of care meeting program standards, and changes in DHS's budgetary capabilities. Interim reimbursement adjustments based on changes in economic factors are subject to the same 2.0% rule as those for legal or regulatory reasons, as cited under subsection (a) of this section. Where adjustments are under consideration based on both changes in rules and regulations as described under subsection (a) of this section and economic factors as described under this subsection, the 2.0% rule is based on the combined impact of both types of influences.

(c) In conducting regular, periodic reimbursement reviews and preparing reimbursement adjustments, DHS takes into consideration changes in laws, rules, regulations, policies, guidelines, or economic factors which will have a demonstrable material impact on most provider costs of providing services meeting federal and state standards.

(d) DHS staff recommends to the Texas Board of Human Services (board) statewide uniform reimbursement amounts and reimbursement ceiling amounts determined in accordance with reimbursement determination rules specific to each program. The board may, if necessary, adjust reimbursement amounts downward to operate within the limits of appropriated funds.

(1) DHS staff recommends to the board for contractor-specific reimbursement the parameter dollar amounts in accordance with reimbursement determination rules specific to each program. The board may, if necessary, adjust reimbursement parameter amounts downward to operate within the limits of appropriated funds.

(2) For the nursing facility program subject to the federal Boren Amendment, downward reimbursement adjustments for budgetary reasons may not exceed the amount of any mark-up or margin over projected costs. For the nursing facility program, this limitation ensures that downward reimbursement adjustments do not reduce reimbursement below the costs which must be incurred by efficient and economic providers meeting federal and state standards.

*§20.110. Informal Reviews and Formal Appeals.*

(a) General provisions.

(1) Definitions. The following words or terms, when used in this section,

shall have the following meaning, unless the context clearly indicates otherwise.

(A) Formal appeal-An administrative hearing requested by an interested party under subsection (d) of this section and conducted in accordance with procedures described at §§79.1601-79.1614 of this title (relating to Formal Appeals).

(B) Informal review-The informal reexamination of an action or determination by the Texas Department of Human Services (DHS) under this chapter requested by an interested party and conducted in accordance with subsection (c) of this section.

(C) Interested party-A DHS-contracted provider.

(2) Standing to file informal reviews or formal appeals. Only an interested party has standing to file for an informal review or formal appeal under this section.

(3) Subject matter of informal reviews and formal appeals. An interested party may request an informal review or formal appeal regarding a DHS action or determination under §§20 102-20.105 of this title (relating to General Principles of Allowable and Unallowable Costs, Specifications for Allowable and Unallowable Costs, Revenues, and General Reporting and Documentation Requirements, Methods and Procedures), or program-specific allowable or unallowable costs, taken specifically in regard to the interested party

(b) Separation of informal reviews and formal appeals from the reimbursement determination process.

(1) The filing of a request for an informal review or formal appeal under this section does not stay or delay implementation of reimbursement adopted by DHS in accordance with the requirements of this chapter.

(2) Closure of cost report databases used in the reimbursement determination process and application of results of pending review or appeal. To facilitate the timely and efficient calculation of reimbursement amounts, DHS closes cost report databases used in the reimbursement determination process prior to the proposal of reimbursement amounts.

(A) Impact on database of pending informal review or formal appeal. If an informal review or formal appeal is pending at the time the database is closed, the database shall include the interested party's cost report data, including, in the case of an informal review, any adjustments made either in the desk review or field audit; and, in the case of a formal appeal, any adjustment required as a result of the informal review.

(B) Uniform reimbursement.

(i) For programs where reimbursement is uniform by class of service and/or provider type, the cost report database used in reimbursement determination is closed six weeks prior to the public hearing on the proposed reimbursement that is based on the cost report database.

(ii) If an informal review or formal appeal is pending at the time the cost report database is closed, the results of the informal review or formal appeal shall be applied during the next reimbursement determination cycle, if applicable.

(C) Contractor-specific reimbursement.

(i) For programs where reimbursement is contractor-specific the cost report database is closed ten weeks prior to the end of the reimbursement determination cycle.

(ii) If an informal review or formal appeal is pending at the time the cost report database is closed, the results of the informal review or formal appeal shall be applied to the interested party's payment retroactively to the beginning of the current reimbursement determination cycle. The results of the informal review or formal appeal shall not be applied to the cost report database as a whole or to any other reimbursement amounts influenced by the cost report database as a whole until the next reimbursement determination cycle, if applicable.

(c) Informal review.

(1) An interested party who disputes a DHS action or determination under this chapter may request an informal review under this section. The purpose of an informal review is to provide for the informal and efficient resolution of the matters in dispute. An informal review is not a formal administrative hearing, but is a prerequisite to obtaining a formal administrative hearing and is conducted according to the following procedures:

(A) The interested party must contact the commissioner of DHS in writing within 20 calendar days of the date on DHS's written notification of the exclusions or adjustments to request an informal review.

(B) An interested party must, with its request for an informal review, submit a concise statement of the specific actions or determinations it disputes, its 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.

(2) On receipt of a request for informal review, the commissioner or his designee assigns the review to appropriate DHS staff.

(A) The lead staff member coordinates a review by appropriate DHS staff of the information submitted by the interested party. Staff may request additional information from the interested party, which must be received in writing by the lead staff member within 14 calendar days of the request for additional information. Information received after 14 days may not be used in the panel's written decision unless the interested party receives approval of the lead DHS staff member to submit the information after 14 days.

(B) Within 30 days of the date the request for informal review is received by DHS or the date additional requested information is received by DHS, the lead staff member must send the interested party its written decision by certified mail, return receipt requested.

(d) Administrative hearings. An interested party who disagrees with the results of an informal review conducted under subsection (c) of this section may file a formal appeal of the review. The interested party must file a written request for a formal appeal with the Hearings Department, Texas Department of Human Services, Mail Code W-613, P.O. Box 149030, Austin, Texas 78714-9030, within 15 calendar days after receiving the DHS review panel's written decision as specified in subsection (c) of this section. The formal appeal is limited to the issues that were considered in the informal review process. The information from the interested party is limited to the pertinent information considered in the informal review process. DHS conducts formal appeals in accordance with the provisions of §§79.1601-79.1614 of this title (relating to Formal Appeals). If there is a conflict between the applicable section of Chapter 79 of this title (relating to Legal Services) and the provisions of this chapter, the provisions of this chapter prevail.

*§20.111. Administrative Contract Violations.* For details regarding the process for vendor hold and contract cancellation in cases where a nursing facility fails to submit a cost report or its cost report is determined to be unauditable, refer to §19.2609 of this title (relating to Vendor Hold). For other programs whose specific published

reimbursement methodology rules do not address administrative contract violations, the Texas Department of Human Services (DHS) may take the following actions for administrative contract violations.

(1) DHS grants the provider a compliance period of no more than 30 calendar days to correct a contract violation. At the end of the compliance period, if DHS determines that a contract violation is not corrected, but determines that the provider has made substantial progress toward correcting the contract violation, DHS may grant an additional one-time extension period of up to 15 calendar days.

(2) If the contract violation is not corrected within the compliance period, DHS imposes vendor hold on payments to the provider.

(3) If a contract violation is not corrected within 60 days from the date the provider is placed on vendor hold, DHS may cancel the provider's contract on the 61st day. A provider may request an informal reconsideration and an appeal hearing. A request for an informational reconsideration must be made in writing to the commissioner of the Texas Department of Human Services, P.O. Box 149030, Austin, Texas 78714-9030. Regulations governing these appeals are specified in §79.1605(a) of this title (relating to Request for a Hearing). If the provider appeals the contract cancellation by DHS and the adverse action is sustained by an administrative law judge or judicial proceeding, the effective date of the contract cancellation is the date the administrative law judge's decision becomes final. Unless otherwise specifically provided for, DHS makes no payment for services provided by the provider after the effective date of the provider's contract cancellation. DHS may continue payments for no more than 30 calendar days from the date DHS cancels or fails to renew a provider's contract if DHS determines that:

(A) reasonable efforts are being made to transfer clients to another provider or to alternate care; and

(B) additional time is needed to effect an orderly transfer of the clients.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 24, 1995.

TRD-9509233 Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

Earliest possible date of adoption: September 1, 1995

For further information, please call: (512) 450-3765

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## Chapter 24. Reimbursement Methodology

## Subchapter A. Determination of Payment Rates

### ∘ 40 TAC §24.101

The Texas Department of Human Services (DHS) proposes an amendment to §24.101, concerning general specifications, in its Reimbursement Methodology chapter. The purpose of the amendment is to clarify to which cost report fiscal years this chapter applies.

Also in this issue of the *Texas Register*, DHS is proposing new Chapter 20 and related policies in Chapters 19, 46, 47, 48, 50, and 52 of this title.

Burton F. Raiford, commissioner, has determined that for the first five-year period the section is in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the section.

Mr. Raiford also has determined that for each year of the first five years the section is in effect the public benefit anticipated as a result of enforcing the section will be to clarify to which cost report fiscal years this chapter applies. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the proposed section.

A public hearing will be held at 3:00 p.m. on August 16, 1995, in the Texas Department of Mental Health and Mental Retardation Central Office auditorium at 909 West 45th Street in Austin.

Questions about the content of this proposal may be directed to Carolyn Pratt at (512) 450-4057 in DHS's Rate Analysis Department. Written comments on the proposal may be submitted to Nancy Murphy, Media and Policy Services-177, Texas Department of Human Services E-205, P.O. Box 149030, Austin, Texas 78714-9030, within 30 days of publication in the *Texas Register*. Contact Kathy Hall in Austin at (512) 450-3702, or a local DHS office, for copies of the proposed rules.

The amendment is proposed under the Human Resources Code, Title 2, Chapters 22 and 32, which authorizes the department to administer public and medical assistance programs; under Texas Civil Statutes, Article 4413(502), §16, which provide the Health and Human Services Commission with the authority to administer federal medical assistance funds.

The amendment implements the Human Resources Code, §§22.001-22.024 and §§32.001-32.040.

*§24.101. General Specifications.* The Texas Department of Human Services (DHS) reimburses Texas Medicaid contracted providers for medical assistance provided to Medicaid recipients. The Texas Board of Human Services determines prospective uniform reimbursement rates at least annually, unless the board decides otherwise. **Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this chapter (relating to Reimbursement Methodology). Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in Chapter 20 of this title (relating to Cost Determination Process).**

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 24, 1995.

TRD-9509234 Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

Earliest possible date of adoption: September 1, 1995

For further information, please call: (512) 450-3765

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## Chapter 46. Residential Care Program

The Texas Department of Human Services (DHS) proposes the repeal of §46. 7001 and new §46.7001 and §46.7002, concerning reimbursement methodology for Residential Care Program, in its Residential Care Program chapter. The purpose of the repeal and new sections is to clarify current reimbursement methodology practice and incorporate cost report procedural changes.

These sections were proposed in the December 30, 1994, issue of the *Texas Register* and withdrawn on June 27, 1995. The current proposal includes the original proposal as revised in response to public comments received during that publication process.

Also in this issue of the *Texas Register*, DHS is proposing new Chapter 20 and related policies in Chapters 19, 24, 47, 48, 50, and 52 of this title.

Burton F. Raiford, commissioner, has determined that for the first five-year period the sections are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the sections.

Mr. Raiford also has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be a better understanding of the reimbursement methodology due to inclusion of additional detail. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the proposal.

A public hearing will be held at 3:00 p.m. on August 16, 1995, in the Texas Department of Mental Health and Mental Retardation Central Office auditorium at 909 West 45th Street in Austin.

Questions about the content of this proposal may be directed to Carolyn Pratt at (512) 450-4057 in DHS's Rate Analysis Department. Written comments on the proposal may be submitted to Nancy Murphy, Media and Policy Services-177, Texas Department of Human Services E-205, P.O. Box 149030, Austin, Texas 78714-9030, within 30 days of publication in the *Texas Register*.

## Support Documents

### • 40 TAC §46.7001

*(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Department of Human Services or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)*

The repeal is proposed under the Human Resources Code, Title 2, Chapter 22, which authorizes the department to administer public assistance programs.

The repeal implements Human Resources Code, §§22.001-22.024.

*§46.7001. Reimbursement Methodology for Residential Care.*

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 24, 1995.

TRD-9509235 Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

Earliest possible date of adoption: September 1, 1995

For further information, please call: (512) 450-3765

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### • 40 TAC §46.7001, §46.7002

The new sections are proposed under the Human Resources Code, Title 2, Chapter 22, which authorizes the department to administer public assistance programs.

The new sections implement Human Resources Code, §§22.001-22.024.

*§46.7001. Reimbursement Methodology for Residential Care Program.*

(a) General requirements. Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §46.7002 of this title (relating to Reimbursement Methodology for Residential Care: 1996 and Subsequent Cost Reports).

(b) Cost reporting.

(1) Cost report submittal. All contracted providers must submit a cost report unless the number of days between the date the first Texas Department of Human Services (DHS) client received services and the provider's fiscal year end is 30 days or fewer.

(2) Excused from submission of cost reports. The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any regulatory agency. Requests to be excused from submitting a cost report must be received by DHS's Rate Analysis Department before the due date of the cost report.

(3) Cost report due date The provider must submit the cost report no later than 90 days following receipt of the cost report forms. DHS may grant an extension of the due date for good cause. Good cause is that cause outside the control of the provider. The provider must submit a request for extension in writing to DHS before the cost report due date. Rate Analysis Department staff respond to requests within ten workdays of receipt

(4) Reporting period. The provider must prepare the cost report to reflect the activities of the provider during the provider's previous fiscal year. Cost reports may be required for other periods at the discretion of DHS

(5) Failure to file an acceptable cost report. If a provider fails to file a cost report according to all applicable rules and instructions, DHS may withhold all provider payments until the provider submits an acceptable report.

(6) Accounting requirements. The provider must ensure that financial and statistical information submitted in cost reports is based upon the accrual method of accounting, except for governmental institutions operated on the cash method of accounting. The provider's treatment of any financial or statistical item must reflect the application of the generally accepted accounting principles (GAAP) approved by the American Institute of Certified Public Accountants.

(7) Financial audits. DHS financial audits are performed according to the requirements stated in §46.5003 of this title (relating to Audits).

(8) Record-keeping requirements. Providers must maintain records according to the requirements stated in §69.205 of this title (relating to Contractor's Records).

(9) Failure to maintain records. If a provider does not maintain adequate records to support the financial and statistical information reported in cost reports, DHS allows 30 days for him to bring record keeping into compliance. If a provider fails to correct deficiencies within 30 days from the date of notification of deficiency, DHS may cancel the provider's contract for services.

(10) Amended cost report due dates. All contracted providers must submit cost reports to DHS in a manner prescribed by DHS. DHS accepts amended cost reports submitted on the request of the provider until 180 days after the due date of the cost report or 15 working days prior to the public hearing on proposed reimbursements, whichever occurs first. Since this is a prospective reimbursement system without a provision for reconciliation, amended cost reports filed after this date have no effect on the reimbursement and are not accepted. Amended cost report information that cannot be verified by ten working days prior to the hearing will not be used in reimbursement determination.

(11) Cost of out-of-state audits. Whenever possible, the records necessary to verify information submitted to DHS on Medicaid cost reports, including related-party transactions and other business activities engaged in by the provider, must be accessible to DHS audit staff in the state of Texas. When records are not available to DHS audit staff within the state, the provider must pay the costs for DHS staff to travel and review the records out-of-state. If a provider fails to reimburse DHS for these costs within 30 days of the request for payment, DHS may request that a hold be placed on the vendor payments until the costs are paid in full.

(c) Reimbursement determination. If cost reports covering less than a full fiscal year of operation are used in reimbursement determination, costs and other data are not annualized for purposes of determining per-unit costs and reimbursement.

(1) Reporting and verification of allowable costs.

(A) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursements. DHS excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information

reported by providers. The purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services and which are consistent with federal and state regulations

(B) Individual cost reports may not be included in the database used for reimbursement determination if.

(i) there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported,

(ii) there is reasonable doubt that a provider entity reflected economic and efficient operation, due to low utilization or operation for less than a full fiscal year, or

(iii) an auditor determines that reported costs are not verifiable.

(C) When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from reimbursement determination for the reasons stated in subparagraph (B)(i) and (ii) of this paragraph.

(2) Residential care reimbursement. DHS determines recommended reimbursement for residential care as follows.

(A) DHS's cost determination process recasts reported allowable expense data in a consistent manner to determine per diem costs Reported allowable expenses are combined into seven cost areas:

(i) direct care,

(ii) food;

(iii) meal preparation,

(iv) activities;

(v) transportation;

(vi) facility; and

(vii) administration.

(B) DHS lowers facility, transportation (vehicle), and administration expenses to reflect expenses for a provider at the lower of:

(i) 85% occupancy rate, or

(ii) the overall average occupancy rate for licensed beds in facilities included in the database during the cost-reporting periods included in the base. The occupancy adjustment is applied if the provider's occupancy rate is below 85% or the overall average, whichever is lower The occupancy adjustment is determined by the individual provider occupancy rate being divided by 85 or the average occupancy rate of all providers in the database.

(C) Payroll taxes and employee benefits are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense for the appropriate group of staff. Employee benefits will be charged to a specific salary line item if the benefits are reported separately The allocated payroll taxes and employee benefits are Federal Insurance Contributions Act or social security, Medicare contributions, Workers' Compensation Insurance, the Federal Unemployment Tax Act, and the Texas Unemployment Compensation Act

(D) Allowable salaries paid to the director, administrator, assistant administrator, owner, or partner who work for the Residential Care contracted provider, may be limited to the 90th percentile of an array of salary costs for the director, administrator, assistant administrator, owner, or partner

(E) Each provider's total reported allowable costs, excluding depreciation and mortgage interest, are projected from the historical cost-reporting period to the prospective reimbursement period. The prospective reimbursement period is the period of time that the reimbursement is expected to be in effect

(F) Cost area per diem expenses are calculated by dividing total reported allowable costs for each cost area by the total days of service DHS rank orders cost area per diem expenses from low to high to produce projected per diem expense arrays

(G) Recommended reimbursement is determined by selecting from each cost area the median day of service and the corresponding per diem expense times 1. 07 The resulting cost area amounts are totaled to become the recommended reimbursement.

(H) The Texas Board of Human Services (board) determines prospective uniform reimbursements at least annually, unless the board decides otherwise.

(3) Exceptions to the reimbursement determination methodology. DHS may adjust reimbursements to compensate for anticipated future changes in the Residential Care Program requirements.

(d) Factors affecting allowable costs. Costs are allowable under this program if the provider ensures that they are:

(1) necessary and reasonable for the proper and efficient administration of a program to deliver services for which DHS has contracted,

(2) authorized or not prohibited under state or local laws or regulations;

(3) consistent with any limitations or exclusions described in this section, federal or state laws, or other governing limitations as to types or amounts of cost items;

(4) consistent with policies, regulations, and procedures that apply uniformly to both the Residential Care Program and other activities of the organization of which the provider is a part;

(5) treated consistently using generally accepted accounting principles (GAAP) appropriate to the circumstances;

(6) not allocable to or included as a cost of any other program in either the current or a prior period; and

(7) the net of all applicable credits

(e) Definition of reasonableness. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by an ordinarily prudent person in the conduct of competitive business. In determining the reasonableness of a given cost, DHS considers the following:

(1) whether the cost is of a type generally recognized as ordinary and necessary for the operation of the business or the performance under the contract;

(2) the restraints or requirements imposed by generally accepted sound business practices, arm's length bargaining, federal and state laws and regulations, and contract terms and specifications; and

(3) the action that a prudent person would take in the circumstances, considering his responsibilities to the public, the government, his employees, clients, shareholders, or members, and the fulfillment of the purpose for which the business was organized.

(f) Unallowable costs. Unallowable costs are expenses incurred by a provider which are not directly or indirectly related to the provision of contracted services according to applicable laws, rules, and standards. The following list is a general guide to the various unallowable costs frequently encountered in cost reports submitted by providers and is not intended to be inclusive of all possible unallowable costs:

(1) advertising expenses other than those for yellow pages advertising, newspaper advertising for employee recruitment, and advertising to meet statutory or regulatory requirements;

(2) allowances for bad debts or other uncommon accounts;

(3) business expense from business operations not related to the provision of services for which DHS has contracted;

(4) contributions to political activities or contributions to charity;

(5) discounts for administrative reasons; courtesy, cash, trade, and quantity discounts; rebates; or other discounts granted;

(6) dues to all political and social organizations, and to professional organizations not directly and predominantly concerned with resident or patient care;

(7) entertainment expenses, except for entertainment which is reported as an employee benefit;

(8) expenses incurred for services not related to the provision of services for which DHS has contracted;

(9) expenses for purchases of goods and services from revenues received from restricted or unrestricted gifts, donations, endowments, and trusts;

(10) expenses which are not the legal obligation of the provider;

(11) expenses of donated items, including depreciation and amortization of the value of the donations,

(12) fees for corporation or association board of directors; partnership or corporation filing fees;

(13) fines and other penalties for violation of statute or ordinance, penalties for late payment of taxes, utilities, mortgages, and other similar penalties;

(14) fund-raising and promotion expenses; public relations expenses;

(15) insurance expenses for life insurance premiums if the beneficiary is the provider organization; and for insurance on assets not related to the delivery of services for which DHS has contracted;

(16) interest expense on loans for assets not related to the delivery of services for which DHS has contracted; interest expenses must be reduced or offset by interest income except interest income from funded depreciation accounts or qualified pension funds;

(17) personal compensation not related to the delivery of services for which DHS has contracted;

(18) personal expenses not related to the delivery of services for which DHS has contracted;

(19) expenses for the purchase of services, facilities or supplies from related organizations or parties must not exceed the lower of the cost to the related party or organization or the price of comparable services, facilities, or supplies purchased in an arm's length transaction;

(20) rental or lease expense on any item not related to the delivery of services for which DHS has contracted;

(21) tax expense for federal, state, or local income tax; any tax levied on assets not related to the delivery of services for which DHS has contracted; and

(22) transportation expenses for vehicles which are not generally suited to functions related to the provision of services for which DHS has contracted.

*§46.7002. Reimbursement Methodology for Residential Care: 1996 and Subsequent Cost Reports.*

(a) General requirements. For the completion and submittal of cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years, providers must apply the information in this section. Texas Department of Human Services (DHS) applies the general principles of cost determination as specified in §20.101 of this title (relating to Introduction).

(b) Cost reporting.

(1) Providers must follow the cost-reporting guidelines as specified in §20.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(2) All contracted providers must submit a cost report unless the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer.

(3) The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any regulatory agency. Requests to be excused from submitting a cost report must be received by DHS's Rate Analysis Department before the due date of the cost report.

(c) Reimbursement determination. If cost reports covering less than a full fiscal year of operation are used in reimbursement determination, costs and other data are not annualized for purposes of determining per-unit costs and reimbursement.

(1) Reporting and verification of allowable costs.

(A) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursements. DHS excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services and which are consistent with federal and state regulations.

(B) Individual cost reports may not be included in the database used for reimbursement determination if.

(i) there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported;

(ii) there is reasonable doubt that a provider entity reflected economic and efficient operation, due to low utilization or operation for less than a full fiscal year; or

(iii) an auditor determines that reported costs are not verifiable.

(C) When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from reimbursement determination for the reasons stated in subparagraph (B)(i) and (ii) of this paragraph.

(2) Residential care reimbursement. DHS determines reimbursement for residential care as follows.

(A) DHS's cost determination process recasts reported allowable expense data in a consistent manner to determine per diem costs. Reported allowable expenses are combined into seven cost areas:

(i) direct care;

(ii) food;

(iii) meal preparation;

(iv) activities;

(v) transportation;

(vi) facility; and

(vii) administration.

(B) DHS lowers facility, transportation (vehicle), and administration expenses to reflect expenses for a provider at the lower of:

(i) 85% occupancy rate; or

(ii) the overall average occupancy rate for licensed beds in facilities included in the database during the cost-reporting periods included in the base. The occupancy adjustment is applied if the provider's occupancy rate is below 85% or the overall average, whichever is lower. The occupancy adjustment is determined by the individual provider occupancy rate being divided by .85 or the average occupancy rate of all providers in the database.

(C) Payroll taxes and employee benefits are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense for the appropriate group of staff. Employee benefits will be charged to a specific salary line item if the benefits are reported separately. The allocated payroll taxes and employee benefits are Federal Insurance Contributions Act or social security, Medicare contributions, Workers' Compensation Insurance, the Federal Unemployment Tax Act, and the Texas Unemployment Compensation Act.

(D) Allowable salaries paid to the director, administrator, assistant administrator, owner, or partner who work for the Residential Care contracted provider, may be limited to the 90th percentile of an array of salary costs for the director, administrator, assistant administrator, owner, or partner.

(E) Each provider's total reported allowable costs, excluding depreciation and mortgage interest, are projected from the historical cost-reporting period to the prospective rate period as described in §20.108 of this title (relating to Determination of Inflation Indices). The prospective rate period is the period of time that the reimbursement is expected to be in effect.

(F) Cost area per diem expenses are calculated by dividing total reported allowable costs for each cost area by the total days of service. DHS rank orders cost area per diem expenses from low to high to produce projected per diem expense arrays.

(G) DHS determines reimbursement by selecting from each cost area the median day of service and the corresponding per diem expense times 1.07. The resulting cost area amounts are totaled to determine the per diem reimbursement.

(3) Exceptions to the reimbursement determination methodology. DHS may adjust reimbursement to compensate for anticipated future changes in the Residential Care Program requirements in accordance with §20.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).

(d) Authority to determine reimbursement The authority to determine reimbursement is specified in §20.101 of this title (relating to Introduction).

(e) Allowable and unallowable costs. In determining whether a cost is allowable or unallowable, providers must follow the guidelines as specified in §20.102 and §20.103 of this title (relating to General Principals of Allowable and Unallowable Costs, and Specifications for Allowable and Unallowable Costs). In addition to these sections, the following allowable and unallowable costs are applicable in the Residential Care Program:

(1) Allowable costs. Medical supplies required to provide Residential Care services are allowable. Allowable medical costs include, but are not limited to, supply costs associated with the administration of medications, such as medication cups, syringes for insulin injections, stethoscopes, blood pressure cuffs, and thermometers.

(2) Unallowable costs. Unallowable costs include, but are not limited to, prescription drugs; non-legend drugs; medical records costs; and compensation for physicians, pharmacists, and medical directors.

(f) Reporting revenue. Revenues must be reported on the cost report in accordance with §20.104 of this title (relating to Revenues).

(g) Reviews and field audits of cost reports. DHS performs desk reviews or field audits of cost reports of contracted providers. The frequency and nature of the field audit are determined by DHS to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §20.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and providers will be notified of the results of a desk review or a field audit in accordance with §20.107 of this title (relating to Notification of Exclusions and Adjustments). Providers may request an informal review and, if necessary, an administrative hearing to dispute an action taken by DHS under §20.110 of this title (relating to Informal Reviews and Formal Appeals).

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 24, 1995.

TRD-9509236

Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

Earliest possible date of adoption: September 1, 1995

For further information, please call: (512) 450-3765

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## Chapter 47. Primary Home Care

The Texas Department of Human Services (DHS) proposes the repeal of §47. 5901 and new §47.5901 and §47.5902, concerning reimbursement methodology for Primary Home Care Services and Family Care Services, in its Primary Home Care chapter. The purpose of the proposal is to clarify current reimbursement methodology practice and incorporate cost report procedural changes. Family care services became an optional service under the Primary Home Care Program effective November 1, 1994. Therefore, the new sections also incorporate the reimbursement methodology for family care services into the rule chapter for primary home care. In addition, the proposal updates the methodology in order to base the determination of unit reimbursements on cost report data rather than on modeled analysis and establishes cost determination rules that are consistent across programs, provide explicit guidelines for auditors, provide specific instructions concerning cost reporting, and provide guidelines in areas such as documentation and allocation methods.

These sections were proposed in the December 30, 1994, issue of the *Texas Register* and withdrawn on June 27, 1995. The current proposal includes the original proposal as revised in response to public comments received during that publication process.

Also in this issue of the *Texas Register*, DHS is proposing new Chapter 20 and related policies in Chapters 19, 24, 46, 48, 50 and 52 of this title.

Burton F. Raiford, commissioner, has determined that for the first five-year period the sections are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the sections.

Mr. Raiford also has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be a better understanding of the reimbursement methodology due to inclusion of additional detail, and a single set of guidelines to facilitate financial accountability relating to service delivery. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the proposal.

A public hearing will be held at 3:00 p.m. on August 16, 1995, in the Texas Department of Mental Health and Mental Retardation Central Office auditorium at 909 West 45th Street in Austin.

Questions about the content of this proposal may be directed to Carolyn Pratt at (512) 450-4057 in DHS's Rate Analysis Department. Written comments on the proposal may

be submitted to Nancy Murphy, Media and Policy Services-177, Texas Department of Human Services E-205, P.O. Box 149030, Austin, Texas 78714-9030, within 30 days of publication in the *Texas Register*. Contact Kathy Hall in Austin at (512) 450-3702, or a local DHS office, for copies of the proposed rules.

## Support Documents

### • 40 TAC §47.5901

*(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Department of Human Services or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)*

The repeal is proposed under the Human Resources Code, Title 2, Chapters 22 and 32, which authorizes the department to administer public and medical assistance programs; and under Texas Civil Statutes, Article 4413(502), §16, which provide the Health and Human Services Commission with the authority to administer federal medical assistance funds.

The repeal implements Human Resources Code, §§22.001-22.024 and §§32.001-32.042.

*§47.5901. Reimbursement Methodology for Primary Home Care Services.*

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 24, 1995.

TRD-9509237 Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

Earliest possible date of adoption: September 1, 1995

For further information, please call: (512) 450-3765

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### • 40 TAC §47.5901, §47.5902

The new sections are proposed under the Human Resources Code, Title 2, Chapters 22 and 32, which authorizes the department to administer public and medical assistance programs; and under Texas Civil Statutes, Article 4413(502), §16, which provide the Health and Human Services Commission with the authority to administer federal medical assistance funds.

The new sections implement Human Resources Code, §§22.001-22.024 and §§32.001-32.042.

*§47.5901. Reimbursement Methodology for Primary Home Care Services and Family Care Services.*

(a) General requirements. Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §47.5902 of this title (relating to Reimbursement Methodology for Primary Home Care and Family Care Services: 1996 and Subsequent Cost Reports)

(b) Cost reporting. Provider agencies must submit financial and statistical information at least annually on cost report forms provided by the Texas Department of Human Services (DHS) or on facsimiles which are formatted according to DHS specifications and are preapproved by DHS staff. All contracted providers must submit a cost report unless the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer. The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity. Requests to be excused from submitting a cost report must be received by the Rate Analysis Department of DHS before the due date of the cost report. The Texas Board of Human Services determines reimbursements as specified in §24.101 and §24.102 of this title (relating to General Specifications and Methodology).

(1) Cost report due date. Provider agencies must submit cost reports to DHS no later than 90 days following receipt of the cost report forms.

(2) Extension of due date. DHS may grant extensions of due dates for good cause. A good cause is defined as one that the provider agency could not reasonably be expected to control. Provider agencies must submit requests for extensions in writing to DHS before the cost report due date. Rate Analysis Department staff respond to requests within ten workdays of receipt.

(3) Reporting period. The provider agency must prepare the cost report to reflect the activities of the provider agency during its previous fiscal year. Cost reports may be required for other periods at the discretion of DHS.

(4) Failure to file an acceptable cost report. If a provider agency fails to file a cost report according to all applicable rules and instructions, DHS may withhold all provider payments until the provider agency submits an acceptable cost report.

(5) Accounting requirements. The provider agency must ensure that financial and statistical information submitted in cost reports is based upon the accrual method of accounting, except for governmental institutions operated on the cash method of accounting. The provider agency's treatment of any financial or statistical item must reflect the application of the generally accepted accounting principles (GAAP) approved by the American Institute of Certified Public Accountants.

(6) Allocation methods. If allocation of cost is necessary, provider agencies must use reasonable methods of allocation. DHS adjusts allocated costs if DHS considers the allocation method to be unreasonable. The provider agency must retain workpapers supporting allocations.

(7) Cost report certification. Provider agencies must certify the accuracy of cost reports submitted to DHS in the format specified by DHS. Provider agencies may be liable for civil and/or criminal penalties in the case of misrepresented or falsified information.

(8) Cost report supplements. DHS may at times require additional financial and statistical information other than the information contained in the cost report.

(9) Review of cost reports. DHS staff review each cost report to ensure that all financial and statistical information submitted conforms to all applicable rules and instructions. The review of the cost report includes a desk audit. DHS reviews all cost reports according to the criteria in §24. 201 of this title (relating to Basic Objectives and Criteria for Desk Review of Cost Reports). If a provider agency fails to complete cost reports according to instructions or rules, DHS returns the cost reports to the provider agency for proper completion. DHS may require information other than that contained in the cost report to substantiate reported information.

(10) On-site audits. DHS may perform on-site audits on all provider agencies that participate in the program. DHS determines the frequency and nature of audits, but ensures that they are not less than that required by federal regulations relating to the administration of the program.

(11) Notification of exclusions and adjustments. DHS notifies providers of exclusions and adjustments to reported expenses made during desk reviews and on-site audits of cost reports as specified in §24.401 of this title (relating to Notification).

(12) Access to records. Each provider agency or its designated agent(s) must allow access to any and all records necessary to verify information submitted to DHS on cost reports. This requirement includes records pertaining to related-party transactions and other business activities engaged in by the provider agency. If a provider agency does not allow inspection of pertinent records within 30 days following written notice from DHS, a hold is placed

on vendor payments until access to the records is allowed. If the provider agency continues to deny access to records, DHS may cancel the provider agency's contract.

(13) Recordkeeping requirements. Provider agencies must maintain records according to the requirements stated in §69.205 of this title (relating to Contractor's Records). Provider agencies must ensure that records are accurate and sufficiently detailed to support the financial and statistical information contained in cost reports.

(14) Failure to maintain adequate records. If a provider agency fails to maintain adequate records to support the financial and statistical information reported in cost reports, DHS allows 30 days for the provider agency to bring recordkeeping into compliance. If a provider agency fails to correct deficiencies within 30 days from the date of notification of the deficiency, DHS may cancel the provider agency's contract for services.

(c) Reimbursement determination. If cost reports covering less than a full fiscal year of operation are used in reimbursement determination, costs and other data are not annualized for purposes of determining per-unit costs and reimbursement. DHS determines reimbursement in the following manner.

(1) Cost determination by cost area. DHS combines reported allowable costs into six cost areas, after allocating payroll taxes to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense and after applying employee benefits directly to the corresponding salary line item.

(A) Primary Home Care (PHC) field supervisors cost area. This includes PHC field supervisors' salaries, wages, training, travel expenses and other expenses. These costs are divided by total hours of PHC service, including total nonpriority and Priority 1 service hours, in order to calculate each provider's PHC field supervisor unit cost.

(B) Nonpriority attendants cost area. This includes PHC and Family Care (FC) attendants' salaries and wages, training, travel and other expenses. These costs are divided by total nonpriority hours of service, including PHC and FC, in order to calculate each provider's nonpriority attendant unit cost.

(C) Administration cost area. This includes administrative salaries and wages, and other administrative expenses. These costs are allocated between nonpriority services for PHC and FC and Priority 1 services for PHC and FC, with $0.18 allocated per Priority 1 hour of service and the remaining administration costs allocated to nonpriority hours of service. The administration costs allocated to nonpriority services are divided by total nonpriority hours of service, combining PHC and FC nonpriority hours, in order to calculate each provider's nonpriority administration unit cost. The administration costs allocated to Priority 1 services are divided by total Priority 1 hours of service, combining PHC Priority 1 hours and FC Priority 1 hours, in order to calculate each provider's Priority 1 administration unit cost.

(D) Facility cost area. This includes building and equipment expenses, and operation and maintenance expenses. These costs are divided by total hours of service, including nonpriority services and Priority 1 services for both PHC and FC, in order to calculate each provider's facility unit cost.

(E) Priority 1 attendants cost area. This includes PHC and FC Priority 1 attendants' salaries and wages, training, travel and other expenses. These costs are divided by total Priority 1 hours of service, combining PHC and FC Priority 1 hours, in order to calculate each provider's Priority 1 attendant unit cost.

(F) Family Care (FC) field supervisors cost area. This includes FC field supervisors' salaries, wages, training, travel expenses and other expenses. For reimbursement effective on or after November 1, 1994, the field supervisor costs from the 1992 Family Care Cost Report are divided by the total hours of FC service reported on the 1992 Family Care Cost Report in order to calculate each provider's FC field supervisor unit cost.

(2) Exclusion of certain reported expenses and cost reports.

(A) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursement. DHS excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services and are consistent with federal and state regulations.

(B) Individual cost reports may not be included in the database used for reimbursement determination if:

(i) there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported;

(ii) there is reasonable doubt that a provider entity reflected economic and efficient operation due to low utilization or operation for less than a full fiscal year; or

(iii) an auditor determines that reported costs are not verifiable.

(C) When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from reimbursement determination for the reasons stated in subparagraph (B)(i) and (ii) of this paragraph.

(3) Projected costs. DHS projects allowable expenses per hour of service from each provider agency's reporting period to the next ensuing reimbursement period. DHS determines reasonable and appropriate economic adjusters as described in §24.301 of this title (relating to Determination of Inflation Indices) to calculate the projected expenses. DHS also adjusts reimbursements where new legislation, regulations, or economic factors affect costs as specified in §24.501 of this title (relating to Adjusting Rates When New Legislation, Regulations, or Economic Factors Affect Costs).

(4) Projected cost arrays. To calculate reimbursement per hour of service, DHS rank-orders from low to high all provider agencies' projected allowable costs per hour of service in each cost area.

(5) Recommended reimbursement for each cost area component. The hours of service used to calculate each cost area component for each provider agency are summed until the median hour of service is reached. The corresponding projected expense is the weighted median cost component. The cost component for each cost area is multiplied by 1.044 to calculate the recommended reimbursement for each cost area component.

(6) Total recommended reimbursement.

(A) For PHC nonpriority clients. DHS determines the recommended reimbursement by summing the recommended reimbursement described in paragraph (5) of this subsection for the cost area components described in paragraph (1) (A)-(D) of this subsection.

(B) For PHC Priority 1 clients. DHS determines the recommended reimbursement by adding the recommended reimbursement described in subparagraph (A) of this paragraph to the recommended reimbursement described in paragraph (5) of this subsection for the cost area component described in paragrah (1)(E) of this subsection.

(C) For Family Care nonpriority clients. For reimbursement effective May 1, 1995, DHS determines the recommended reimbursement by summing the recommended reimbursement described in paragraph (5) of this subsection for the cost area components described in paragraph (1)(B)-(D) and (F) of this subsection.

(D) For Family Care Priority 1 clients. DHS determines the recommended reimbursement by adding the recommended reimbursement described in subparagraph (C) of this paragraph to the recommended reimbursement described in paragraph (5) of this subsection for the cost area component described in paragraph (1)(E) of this subsection.

(7) Reimbursement determination authority. The Texas Board of Human Services recommends for approval to the Texas Health and Human Services Commission Primary Home Care reimbursements, based on the methodology in the state plan and the provisions of which are included in this chapter. The Texas Board of Human Services approves Family Care reimbursements, as these are non-Medicaid services.

(8) Reviews of cost report disallowances. A provider agency may request notification of the exclusions and adjustments to reported expenses made during either desk reviews or on-site audits according to §24.401 of this title (relating to Notification). Providers may request an informal review and, if necessary, an administrative hearing to dispute an action taken by DHS under §24.601 of this title (relating to Reviews and Administrative Hearings) .

(d) Factors affecting allowable costs. To be allowable under this program, costs must be:

(1) necessary and reasonable for the proper and efficient administration of the program to deliver services for which DHS has contracted;

(2) authorized or not prohibited under state or local laws or regulations;

(3) consistent with any limitations or exclusions described in this section, federal or state laws, or other governing limitations as to types or amounts of cost items;

(4) consistent with policies, regulations, and procedures that apply uniformly to both the Primary Home Care Program and other activities of the organization of which the provider agency is a part;

(5) treated consistently using generally accepted accounting principles appropriate to the circumstances;

(6) not allocable to or included as a cost of any other program in either the current or a prior period; and

(7) the net of all applicable credits.

(e) Definition of reasonableness. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by an ordinarily prudent person in the conduct of competitive business. In determining the reasonableness of a given cost, DHS considers the following:

(1) whether the cost is of a type generally recognized as ordinary and necessary for the operation of the business or the performance under the contract;

(2) the restraints or requirements imposed by generally accepted sound business practices, arm's length bargaining, federal and state laws and regulations, and contract terms and specifications; and

(3) the action that a prudent person would take in the circumstances, considering his responsibilities to the public, the government, his employees, clients, shareholders, or members, and the fulfillment of the purpose for which the business was organized.

(f) Unallowable costs. Unallowable costs are expenses incurred by a provider agency which are not directly or indirectly related to the provision of contracted services according to applicable laws, rules, and standards. A provider agency may expend funds on unallowable cost items, but those costs must not be included in the cost report and are not used in calculating a reimbursement recommendation. The following list is a general guide to the various unallowable costs frequently encountered in cost reports submitted by provider agencies and is not intended to be inclusive of all possible unallowable costs:

(1) advertising expenses other than those for employee recruitment, yellow page listings no larger than one column width and one inch length, and advertising to meet statutory or regulatory requirements;

(2) allowances for bad debts or other similar accounts;

(3) business expenses not related to the provision of services for which DHS has contracted;

(4) contributions to political activities or contributions to charity;

(5) corporate headquarters expenses that are not directly involved in providing services or supplies used by the home health agency staff in normal operations relating to primary home care;

(6) depreciation expenses other than those based on straight-line depreciation;

(7) discounts for administrative reasons; courtesy, cash, trade, and quantity discounts; rebates; or other discounts granted;

(8) dues and membership fees to organizations whose primary emphasis is not related to the services for which DHS has contracted;

(9) entertainment expenses, except for entertainment which is reported as an employee benefit;

(10) expenses incurred for services not related to the provision of services for which DHS has contracted;

(11) expenses for purchases of goods and services from revenues received from restricted or unrestricted gifts, donations, endowments, and trusts;

(12) expenses which are not the legal obligation of the provider agency;

(13) expenses of donated items, including depreciation and amortization of the value of the donations;

(14) fees and travel expenses for corporation or association board of directors; partnership or corporation filing fees;

(15) fines and other penalties for violation of statutes or ordinances; penalties for late payment of taxes, utilities, mortgages, loans, and other similar penalties;

(16) franchise fees;

(17) fund-raising and promotion expenses; public relations expenses;

(18) expenses for life insurance premiums where the beneficiary is the provider organization unless life insurance is a requirement of a loan agreement and the loan is related to client care;

(19) interest expense on loans for assets not related to the delivery of services for which DHS has contracted; interest expenses must be reduced or offset by interest income except interest income from funded depreciation accounts or qualified pension funds;

(20) medical equipment and supplies (except those required by OSHA, those used for universal health and safety precautions, and those otherwise needed to meet program requirements);

(21) personal compensation not related to the delivery of services for which DHS has contracted;

(22) personal expenses not related to the delivery of services for which DHS has contracted;

(23) physicians' fees for completion of physician orders;

(24) expenses for the purchase of services, facilities, or supplies from related organizations or parties if the expenses exceed the lower of the cost to the related party or organization or the price of comparable services, facilities, or supplies purchased in an arm's length transaction;

(25) rental or lease expense on any item not related to the delivery of services for which DHS has contracted;

(26) tax expense for federal, state, or local income tax; any tax levied on assets not related to the delivery of services for which DHS has contracted; and

(27) transportation expenses for vehicles which are not generally suited to functions related to the provision of services for which DHS has contracted. Mileage expense may be included at a cost per mile not to exceed the current reimbursement rate set by the legislature for state employee travel. Mileage is allowable if there is adequate documentation of the mileage and if the expense was related to delivery of services for which DHS has contracted.

*§47.5902. Reimbursement Methodology for Primary Home Care and Family Care Services: 1996 and Subsequent Cost Reports.*

(a) General requirements. For the completion and submittal of cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years, providers must apply the information in this section. Texas Department of Human Services (DHS) applies the general principles of cost determination as specified in §20.101 of this title (relating to Introduction)

(b) Cost reporting. Providers must follow the cost-reporting guidelines as specified in §20.105 of this title (relating to General Reporting and Documentation Requirements, Methods and Procedures).

(1) All contracted providers must submit a cost report unless the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer. The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity. Requests to be excused from submitting a cost report must be received by DHS's Rate Analysis Department before the due date of the cost report.

(2) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursement. DHS excludes from reimbursement determination unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services and are consistent with federal and state regulations. Individual cost reports may not be included in the database used for reimbursement determination where there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported; when there is reasonable doubt that a provider entity reflected economic and efficient operation and long-term viability, due to low utilization or operation for less than a full fiscal year; or when an auditor determines that reported costs are not verifiable.

(c) Reimbursement determination. If cost reports covering less than a full fiscal year of operation are used in reimbursement determination, costs and other data are not annualized for purposes of determining per-unit costs and reimbursement. DHS determines reimbursement in the following manner.

(1) Cost determination by cost area. DHS combines reported allowable costs into six cost areas, after allocating payroll taxes to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense and after applying employee benefits directly to the corresponding salary line item.

(A) Primary Home Care field supervisors cost area. This includes Primary Home Care field supervisors' salaries, wages, training, and travel expenses. These costs are divided by total hours of Primary Home Care service, including total nonpriority and Priority 1 service hours, in order to calculate each provider's Primary Home Care field supervisor unit cost.

(B) Nonpriority attendants cost area. This includes nonpriority Primary Home Care and Family Care attendants' salaries and wages, and travel expenses. These costs are divided by total nonpriority hours of service, including Primary Home Care and Family Care nonpriority service hours, in order to calculate each provider's nonpriority attendant unit cost.

(C) Administration cost area. This includes administrative salaries and wages, and other administrative expenses. These costs are allocated between nonpriority services and Priority 1 services, with $0.18 allocated per Priority 1 hour of service and the remaining administration costs allocated to nonpriority hours of service. The administration costs allocated to nonpriority services are divided by total nonpriority hours of service, including Primary Home Care and Family Care nonpriority service hours, in order to calculate each provider's nonpriority administration unit cost. The administration costs allocated to Priority 1 services are divided by total Priority 1 hours of service, including Primary Home Care and Family Care Priority 1 service hours, in order to calculate each provider's Priority 1 administration unit cost.

(D) Facility cost area. This includes building and equipment expenses, and operation and maintenance expenses.

(E) Priority 1 attendants cost area. This includes Priority 1 Primary Home Care and Family Care attendants' salaries and wages, and travel expenses. These costs are divided by total Priority 1 hours of service, including Primary Home Care and Family Care Priority 1 service hours, in order to calculate each provider's Priority 1 attendant unit cost.

(F) Family Care field supervisors cost area. This includes Family Care field supervisors' salaries, wages, training, and travel expenses. For reimbursement effective on or after November 1, 1994, the field supervisor costs from the 1992 Family Care Cost Report are divided by the total hours of Family Care service reported on the 1992 Family Care Cost Report in order to calculate each provider's Family Care field supervisor unit cost.

(2) Projected costs. DHS projects allowable expenses per hour of service from each provider agency's reporting period to the next ensuing reimbursement period. DHS determines reasonable and appropriate economic adjusters as described in §20.108 of this title (relating to Determination of Inflation Indices) to calculate the projected expenses. For providers reporting traditional workers' compensation insurance (WCI) policy premium costs, their reported workers' compensation costs are inflated by applying the WCI index as calculated in §20.108(c)(2) of this title (relating to Determination of Inflation Indices), plus additional inflation percentages for a risk pool

surcharge and for premium differential and modifiers associated with the home health industry. DHS also adjusts reimbursement where new legislation, regulations, or economic factors affect costs as specified in §20.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs). Depreciation and mortgage interest expenses are not projected.

(3) Projected cost arrays. To calculate the reimbursement per hour of service, DHS rank orders from low to high all provider agencies' projected allowable costs per hour of service in each cost area and all provider agencies' projected total costs.

(4) Recommended reimbursement for each cost area component. The hours of service used to calculate each cost area component for each provider agency are summed until the median hour of service is reached. The corresponding projected expense is the weighted median cost component. The cost component for each cost area is multiplied by 1.044 to calculate the recommended reimbursement for each cost area component.

(5) Total recommended reimbursement.

(A) For Primary Home Care nonpriority clients. DHS determines the recommended reimbursement by summing the recommended reimbursement described in paragraph (4) of this subsection for the cost area components described in paragraph (1)(A)-(D) of this subsection.

(B) For Primary Home Care Priority 1 clients. DHS determines the recommended reimbursement by adding the recommended reimbursement described in subparagraph (A) of this paragraph to the recommended reimbursement described in paragraph (4) of this subsection for the cost area component described in paragraph (1)(E) of this subsection.

(C) For Family Care nonpriority clients. For reimbursement effective May 1, 1995, DHS determines the recommended reimbursement by summing the recommended reimbursement described in paragraph (4) of this subsection for the cost area components described in paragraph (1)(B)-(D) and (F) of this subsection.

(D) For Family Care Priority 1 clients. DHS determines the recommended reimbursement by adding the recommended reimbursement described in subparagraph (C) of this paragraph to the recommended reimbursement described in paragraph (4) of this subsection for the cost area component described in paragraph (1)(E) of this subsection.

(6) Reimbursement determination authority. The reimbursement determination authority is specified in §20.101 of this title (relating to Introduction).

(7) Desk reviews and field audits of cost reports. DHS performs desk reviews or field audits on all contracted providers. The frequency and nature of the field audits are determined by DHS to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §20.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and providers will be notified of the results of a desk review or an audit in accordance with §20.107 of this title (relating to Notification of Exclusions and Adjustments). Providers may request an informal review and, if necessary, an administrative hearing to dispute an action taken by DHS under §20.110 of this title (relating to Informal Reviews and Formal Appeals).

(d) Factors affecting allowable costs. Providers must follow the guidelines in determining whether a cost is allowable or unallowable as specified in §20.102 this title (relating to General Principles of Allowable and Unallowable Costs) and §20.103 of this title (relating to Specifications for Allowable and Unallowable Costs).

(e) Reporting revenues. Revenues must be reported on the cost report in accordance with §20.104 of this title (relating to Revenues).

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 24, 1995.

TRD-9509238

Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

Earliest possible date of adoption: September 1, 1995

For further information, please call: (512) 450-3765

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## Chapter 48. Community Care for Aged and Disabled

The Texas Department of Human Services (DHS) proposes the repeal of §48.9805, an amendment to §48.2613 and new §48.2614, concerning Client-managed Attendant Services, an amendment to §48.6020 and new §48.6021, concerning 1915(c) Medicaid Home and Community-based Waiver Services for Aged and Disabled Adults Who Meet Criteria for Alternatives to Nursing Facility Care, an amendment to §48.9801 and new §§48.9802, 48.9805, and 48.9806, an amendment to §48.9808, new §48.9809, an amendment to §48.9811, and new §48.9812, concerning reimbursement methodology. The purpose of the repeal and amendments is to clarify current reimbursement methodology practice and incorporate cost report procedural changes. The purpose of the new sections is to establish cost determination rules that are consistent across programs, provide explicit guidelines for auditors, provide specific instructions concerning cost reporting, and provide guidelines in areas such as documentation and allocation methods. The new sections will also clarify current reimbursement methodology practice and incorporate cost report procedural changes.

These sections were proposed in the December 30, 1994, issue of the *Texas Register* and withdrawn on June 27, 1995. The current proposal includes the original proposal as revised in response to public comments received during that publication process.

Also in this issue of the *Texas Register*, DHS is proposing new Chapter 20 and related policies in Chapters 19, 24, 46, 47, 50, and 52 of this title.

Burton F. Raiford, commissioner, has determined that for the first five-year period the sections are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the sections.

Mr. Raiford also has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be a single set of guidelines to facilitate financial accountability relating to service delivery and a better understanding of the reimbursement methodology due to inclusion of additional detail. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the proposed sections.

A public hearing will be held at 3:00 p.m. on August 16, 1995, in the Texas Department of Mental Health and Mental Retardation Central Office auditorium at 909 West 45th Street in Austin.

Questions about the content of this proposal may be directed to Carolyn Pratt at (512) 450-4057 in DHS's Rate Analysis Department. Written comments on the proposal may be submitted to Nancy Murphy, Media and Policy Services-177, Texas Department of Human Services E-205, P.O. Box 149030, Austin, Texas 78714-9030, within 30 days of publication in the *Texas Register*. Contact Kathy Hall in Austin at (512) 450-3702, or a local DHS office, for copies of the proposed rules.

### Client-Merged Attendant Services

• **40 §48.2613, §48.2614**

The amendment and new section are proposed under the Human Resources Code, Title 2, Chapter 22, which authorizes the department to administer public assistance programs.

The amendment and new section implement the Human Resources Code, §§22.001-22.024.

*§48.2613. Cost Reporting Guidelines for Client-managed Attendant Services.*

**(a) General requirements. Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §48.2614 of this title (relating to Cost Reporting for Client-Managed Attendant Services: 1996 and Subsequent Cost Reports).**

**(b)[(a)] Definition of contracted provider.** The term contracted provider, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise. An agency that has contracted with the Texas Department of Human Services (DHS) to provide the Community Care for Aged and Disabled (CCAD) Services that DHS has authorized for eligible clients.

**(c)[(b)] Cost reporting.** Contracted providers must submit financial and statistical information at least annually on cost report forms provided by DHS or on facsimiles preapproved by DHS and formatted according to DHS specifications. Contract-specific **reimbursements** [reimbursement rates] are determined through either the procurement or **reimbursement** [rate] negotiation process with DHS staff and the contracted provider. The reimbursement [rate] is per hour of service.

(1) Cost report due date. Contracted providers must submit cost reports to DHS by the due date stated in the cost report transmittal letter, which is usually 90 days following the receipt of the cost report forms. **All contracted providers must submit a cost report unless the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer. The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity. Requests to be excused from submitting a cost report must be received by DHS's Rate Analysis Department before the due date of the cost report.**

(2) Extension of due date. DHS may grant extensions of due dates for good cause. Good cause is defined as a situation that the provider could not reasonably be expected to control. Contracted providers must submit requests for extensions to DHS in writing before the cost report due date. **Rate Analysis** [Provider Reimbursement] Department staff respond to requests within ten workdays of receipt.

(3) Reporting period. The contracted provider must prepare the cost report to reflect the activities of the contracted provider during its previous fiscal year. Cost reports may be required for other periods at the discretion of DHS.

(4) Failure to file an acceptable cost report. If a contracted provider fails to file a cost report according to all applicable rules and instructions, DHS may withhold all provider payments until the contracted provider submits an acceptable cost report.

(5) Accounting requirements. The contracted provider must ensure that financial and statistical information submitted in cost reports is based upon the accrual method of accounting, except for governmental institutions operated on the cash or modified accrual method of accounting. The contracted provider's treatment of any financial or statistical item must reflect the application of the generally accepted accounting principles (GAAP) approved by the American Institute of Certified Public Accountants (AICPA).

(6) Allocation methods. If allocation of costs is necessary, contracted providers must use reasonable methods of allocation. DHS adjusts allocated costs if it considers the allocation method is unreasonable. The contracted provider must retain workpapers supporting allocations.

(7) Cost report certification. Contracted providers must certify the accuracy of cost reports submitted to DHS in the format specified by DHS. Contracted providers may be liable for civil and/or criminal penalties in the case of misrepresented or falsified information.

(8) Cost report supplements. DHS may require additional financial and statistical information other than the information contained in the cost report.

(9) Review of cost reports. DHS staff review each cost report to ensure that all financial and statistical information submitted conforms to all applicable rules and instructions. The review of the cost report includes a desk audit. If a contracted provider fails to complete a cost report according to instructions or rules, DHS returns the cost report to the contracted provider for proper completion. DHS may require information other than that contained in the cost report to substantiate reported information.

(10) Onsite audits. DHS may perform onsite audits on all contracted providers that participate in the program. DHS determines the frequency and nature of audits, but ensures that they are not less than that required by regulations relating to the administration of the program. Failure to allow DHS to perform an audit in sufficient detail to verify reported information may result in the withholding of provider payments.

(11) Cost of out-of-state audits. When possible, the records necessary to verify information submitted to DHS on cost reports, including related-party transactions and other business activities engaged in by the provider, must be accessible to DHS audit staff in Texas. When records are not available to DHS audit staff within the state, the contracted provider must pay the costs for DHS staff to travel and review the records out-of-state. If a provider fails to reimburse DHS for these costs within 30 days of the request for payment, DHS may place a hold on the provider's vendor payments until the costs are paid in full.

(12) Notification by regular mail. DHS notifies providers by regular mail of exclusions and adjustments to reported expenses made during desk reviews and onsite audits of cost reports.

(A) DHS mails notices of desk-review exclusions and adjustments within ten workdays after entering them in the cost-report data base. The notice consists of a one-page desk-review audit adjustment sheet that specifies the line-items on the cost report that have been adjusted or excluded, the amount of each adjustment or exclusion, and the principal reason for each adjustment or exclusion.

(B) DHS mails each onsite audit report within 30 days after the final exit interview with the contracted provider. An exit interview is final when DHS audit staff have received, reviewed, and analyzed all documentation from the contracted provider pertinent to the scope of the audit. The onsite audit report consists of a multiple-page professional report prepared by DHS audit staff to enumerate the results of the onsite audit. Each onsite audit report includes a specification of cost-report line-items that have been adjusted or excluded, the amount of each adjustment or exclusion, and the principal reason for each adjustment or exclusion.

(C) DHS mails onsite audit reports and notices of desk-review exclusions and adjustments to the addresses that providers have given to DHS as their standard mailing addresses. However, if a provider submits a written request for DHS to send an onsite audit report or a notice of desk-review exclusions and adjustments to another address, DHS must do so.

(D) A provider may also submit a written request for DHS to provide

additional information about exceptions and adjustments to the provider's cost reports, including citations of the laws or regulations that constitute the grounds for the exceptions and adjustments. DHS must provide the additional information in writing within 30 calendar days.

(13) Access to records. Each contracted provider or its designated agent(s) must allow access to any and all records necessary to verify information submitted to DHS on cost reports. This requirement includes records pertaining to related-party transactions and other business activities engaged in by the contracted provider. If a contracted provider does not allow inspection of pertinent records within 30 days following written notice from DHS, a hold is placed on vendor payments until access to the records is allowed. If the provider continues to deny access to records, DHS may cancel the provider's contract.

(14) Recordkeeping requirements. Contracted providers must maintain records according to the requirements stated in §69.205 [§69.202] of this title (relating to Contractors' Records). Contracted providers must ensure that records are accurate and sufficiently detailed to support the financial and statistical information contained in cost reports. If a provider fails to maintain adequate records to support the financial and statistical information reported in cost reports, DHS allows 30 [90] days for the contracted provider to bring recordkeeping into compliance. If a provider fails to correct deficiencies within 30 [90] days from the date of notification of the deficiency, DHS may cancel the provider's contract for services.

(15) Amended cost report due dates. Contracted providers must submit cost reports to DHS in a manner prescribed by DHS. DHS accepts amended cost reports submitted on the request of the provider until 180 days after the due date of the cost report.

(16) Exclusion of certain reported expenses and cost reports. [Contracted providers must ensure that all unallowable costs are eliminated from the cost report. DHS excludes any unallowable costs that are included in the cost report.]

**(A) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determined recommended reimbursement. DHS excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services and consistent with federal and state regulations.**

**(B) Individual cost reports may not be included in the database used for compilation of provider cost profiles if:**

***(i)*** **there is doubt as to the accuracy or allowability of a significant part of the information reported;**

***(ii)*** **there is reasonable doubt that a provider entity reflected economic and efficient operation due to low utilization or operation for less than a full fiscal year; or**

***(iii)*** **an auditor determines that reported costs are not verifiable.**

**(C) When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from the database used for compilation of provider cost profiles for reasons stated in subparagraph (B)(i) and (ii) of this paragraph.**

**(d) Reimbursement determination. Reimbursement per hour of service is determined for each individual contracted provider by its DHS contract manager. The reimbursement determination is based upon estimated costs reported by the contracted provider for the effective reimbursement period and upon historical information reported by the contracted provider in the form of annual cost reports covering the provider's fiscal year. Comparisons of each provider's individual cost profiles per unit of service from prior years, as well as comparisons with mean and weighted median cost profiles per unit of service across all providers, are used by the DHS contract manager in the reimbursement determination process. If cost reports covering less than a full fiscal year of operation are used in reimbursement determination, costs and other data are not annualized for purposes of determining per-unit costs and reimbursement.**

**(1) Cost areas. Allowable costs, reported or estimated, are combined into five cost areas, after allocating payroll taxes to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expenses and after applying employee benefits directly to the corresponding salary line item.**

**(A) Assessors of Need Cost Area. This cost area collects costs and statistics associated with assessors of need, including salaries, travel expenses, training costs, and contracted expenses.**

**(B) Attendant Recruitment and Orientation Cost Area. This cost area collects costs and statistics associated with persons recruiting and orienting attendants, including salaries, travel expenses, training costs, contracted expenses, and advertising costs for attendant recruitment.**

**(C) Attendants Cost Area. This cost area collects costs and statistics associated with regular and substitute attendants, as well as on-call staff, including salaries, travel expenses, training costs, universal health and safety costs, and other miscellaneous costs.**

**(D) Building and Transportation Cost Area. This cost area collects building and building equipment expenses, departmental equipment expenses, and transportation equipment expenses.**

**(E) Administration Cost Area. This cost area collects administrative salaries, office expenses, and central office overhead expenses.**

(2)[(17)] Projected costs. DHS projects allowable expenses per hour of service from each contracted provider's reporting period to the next reimbursement [rate] period. DHS determines reasonable and appropriate economic adjusters to calculate the projected expenses. DHS also may adjust reimbursements [adjusts rates] if new legislation, regulations, or economic factors affect costs.

**(3) Provider Cost Profiles.**

**(A) Individual provider cost profile per unit of service. To determine a provider's individual cost profile, DHS determines a cost component for each cost area in paragraph (1)(A)-(E) of this subsection by dividing either the total reported or the total projected allowable costs for the cost area by the total units of service provided. The sum of the five cost components is the provider's individual reported or projected cost per unit of service.**

**(B) Mean cost profile per unit of service across all providers. To determine the mean cost profile across all providers submitting cost reports, DHS takes the results from subparagraph (A) of this paragraph for each provider and**

calculates a mean (average) for each cost area. The sum of the mean cost area components is the mean cost profile (reported or projected) per unit of service across all providers.

(C) Weighted median cost profile per unit of service across all providers. To determine the weighted median cost profile across all providers submitting cost reports, DHS rank-orders from low to high all providers' (reported or projected) cost per hour of service in each cost area. The hours of service for each provider that correspond with each cost array are summed until the median hour of service is reached, resulting in a weighted median cost area component. The sum of the five weighted median cost area components is the weighted median cost profile per unit of service across all providers.

(e)[(18)] Allowable costs. To be allowable under client-managed attendant services, costs must be:

(1)[(A)] necessary and reasonable for the proper and efficient administration of the program to deliver services for which DHS has contracted;

(2)[(B)] authorized or not prohibited under state or local laws or regulations;

(3)[(C)] consistent with any limitations or exclusions described in this section, federal or state laws, or other governing limitations as to types or amounts of cost items;

(4)[(D)] consistent with policies, regulations, and procedures that apply uniformly to both the Client-Managed Attendant Services Program and other activities of the organization of which the contracted provider is a part;

(5)[(E)] treated consistently using generally accepted accounting principles appropriate to the circumstances;

(6)[(F)] not allocable to or included as a cost of any other program in either the current or a prior period; and

(7)[(G)] the net of all applicable credits.

(f)[(19)] Definition of reasonableness. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by an ordinarily prudent person in the conduct of competitive business. In determining the reasonableness of a given cost, DHS considers the following:

(1)[(A)] whether the cost is a type generally recognized as ordinary and necessary for the operation of the business or the performance under the contract;

(2)[(B)] the restraints or requirements imposed by generally accepted sound business practices, arm's length bargaining, federal and state laws and regulations, and contract terms and specifications; and

(3)[(C)] the action that a prudent person would take in the circumstances, considering his responsibilities to the public, the government, his employees, clients, shareholders, or members, and the fulfillment of the purpose for which the business was organized.

(g)[(20)] Unallowable costs. Unallowable costs are expenses incurred by a contracted provider which are not directly or indirectly related to the provision of contracted services according to applicable laws, rules, and standards. A contracted provider may expend funds on unallowable cost items, but those costs must not be included in the cost report and are not used in arriving at a contract-specific reimbursement [rate]. The information contained in paragraphs (1)-(36) of this subsection [subparagraphs (A)-(JJ) of this paragraph] is a general guide to the various unallowable costs frequently encountered in cost reports submitted by contracted providers and is not intended to be inclusive of all possible unallowable costs:

(1)[(A)] advertising expenses other than those for employee recruitment, yellow page listings no larger than one column width and one inch length, and advertising to meet statutory or regulatory requirements;

(2)[(B)] allowances for bad debts, other allowances, returns, refunds, or other similar accounts;

(3)[(C)] business, personal, or other expenses not related to the provision of services for which DHS has contracted;

(4)[(D)] contributions to political activities or contributions to charity;

(5)[(E)] corporate headquarters or central office expenses that are not directly involved in providing services or supplies used by the contracted provider's staff in normal operations relating to client-managed attendant services;

(6)[(F)] depreciation expenses other than those based on straight-line depreciation; building depreciation expenses based on less than a 30-year life; depreciation and amortization of unallowable costs, including amounts in excess of those resulting from the straight-line method, capitalized lease expenses in excess of actual lease payments, and goodwill or any excess above the actual value of physical assets at the time of purchase;

(7)[(G)] discounts for administrative reasons; courtesy, cash, trade, and quantity discounts; rebates; or other discounts granted;

(8)[(H)] dues and membership fees to organizations whose primary emphasis is not related to the services for which DHS has contracted;

(9)[(I)] dues to all types of political and social organizations, and to professional associations not directly and primarily concerned with the provision of services for which DHS has contracted;

(10)[(J)] entertainment expenses, except for entertainment which is reported as an employee benefit;

(11)[(K)] expenses for purchases of goods and services from revenues received from restricted or unrestricted gifts, donations, endowments, and trusts;

(12)[(L)] expenses which are not the legal obligation of the contracted provider or are not clearly enumerated as to dollar amount;

(13)[(M)] expenses of donated items (facilities, materials, supplies, services, etc.), including depreciation and amortization of the value of the donations, and values assigned to the services of unpaid workers or volunteers;

(14)[(N)] fees and travel expenses for corporation or association board of directors, and partnership or corporation filing fees;

(15)[(O)] fines and other penalties for violation of statutes or ordinances; penalties for late payment of taxes, utilities, mortgages, loans; insufficient fund bank charges; and other similar penalties;

(16)[(P)] franchise fees;

(17)[(Q)] fundraising, promotion, and public relations expenses;

(18)[(R)] expenses for life insurance premiums where the beneficiary is the provider organization, unless life insurance is a requirement of a loan agreement and the loan is related to client care;

(19)[(S)] interest expense on loans for assets not related to the delivery of services for which DHS has contracted; interest expense on loans pertaining to unallowable items; and interest expenses on that portion of interest paid which is reduced or offset by interest income (interest expenses must be reduced or offset by interest income except interest income from funded depreciation accounts or qualified pension funds);

(20)[(T)] medical equipment and supplies (except those required by the Occupational Safety and Health Administration, those used for universal health and safety precautions, and those otherwise needed to meet program requirements);

(21)[(U)] personal compensation not related to the delivery of services for which DHS has contracted;

(22)[(V)] physicians' fees for completion of physician orders;

(23)[(W)] expenses for the purchase of services, facilities, or supplies from related organizations or parties if the expenses exceed the lower of the cost to the related party or organization or the price of comparable services, facilities, or supplies purchased in an arm's length transaction;

(24)[(X)] rental or lease expense on any item not related to the delivery of services for which DHS has contracted;

(25)[(Y)] tax expense for federal, state, or local income tax, and any tax levied on assets not related to the delivery of services for which DHS has contracted;

(26)[(Z)] any expense, and corresponding revenues, that are reimbursed directly through voucher payment systems which are outside of the per-hour **reimbursement** [rate] payment system;

(27)[(AA)] expenses which cannot be adequately documented;

(28)[(BB)] motor vehicles that are not generally suited or are not commonly used to transport clients or contracted provider supplies This includes motor homes and recreational vehicles; sports and luxury automobiles; motorcycles; heavy trucks, tractors and equipment used in farming, ranching, and construction; and other activities unrelated to the provision of client-managed attendant services;

(29)[(CC)] transportation expenses for vehicles which are not generally suited to functions related to the provision of services for which DHS has contracted. Mileage expense may be included at a cost per mile not to exceed the current reimbursement [rate] set by the legislature for state employee travel. Mileage is allowable if there is adequate documentation of the mileage and if the expense was related to delivery of services for which DHS has contracted;

(30)[(DD)] any expense incurred because of imprudent business practices;

(31)[(EE)] out-of-state travel expenses, except for the provision of client-care-related services to contracted provider personnel, which include training and quality assurance functions;

(32)[(FF)] forms of compensation that are not clearly enumerated as to dollar amount or which represent profit distributions;

(33)[(GG)] management fees paid to a related organization that are not clearly derived from the actual cost of materials, supplies, or services provided directly to the contracted provider;

(34)[(HH)] insurance premiums pertaining to items of unallowable cost;

(35)[(II)] contributions to self-insurance funds which do not represent payments based on current liabilities; and

(36)[(JJ)] any expense not allowable under other pertinent federal, state, or local laws and regulations.

*§48.2614. Cost Reporting for Client-Managed Attendant Services: 1996 and Subsequent Cost Reports.*

(a) General requirements. For the completion and submittal of cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years, providers must apply the information in this section. The Texas Department of Human Services (DHS) applies the general principles of cost determination as specified in §20.101 of this title (relating to Introduction).

(b) Cost reporting. Providers must follow the cost-reporting guidelines as specified in §20.105 of this title (relating to General Reporting and Documentation Requirements, Methods and Procedures). All contracted providers must submit a cost report unless the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer. The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity. Requests to be excused from submitting a cost report must be received by the Rate Analysis Department of DHS before the due date of the cost report.

(c) Guidelines for desk reviews and field audits. Guidelines for desk review of cost reports are specified in §20.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports). DHS performs desk reviews or field audits on all contracted providers. The frequency and nature of the field audits are determined by DHS to ensure the fiscal integrity of the program. Providers will be notified of the results of a desk review or field audit in accordance with §20.107 of this title (relating to Notification of Exclusions and Adjustments). Providers may request an informal review and, if necessary, an administrative hearing to dispute an action taken by DHS under §20.110 of this title (relating to Informal Reviews and Formal Appeals). The reimbursement authority is specified in §20.101 of this title (relating to Introduction).

(d) Factors affecting allowable costs.

(1) Guidelines in determining allowable and unallowable costs. Providers must follow the guidelines in determining whether a cost is allowable or unallowable as specified in §20.102 of this title (relating to General Principles and Definitions of Allowable and Unallowable Costs).

(2) Guidelines for allowable and unallowable costs. Providers must follow the guidelines for allowable and unallowable costs as specified in §20.103 of this title (relating to Specifications for Allowable and Unallowable Costs).

(3) Exclusion of certain reported expenses and cost reports.

(A) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursement. DHS excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services and consistent with federal and state regulations.

(B) Individual cost reports may not be included in the database used for compilation of provider cost profiles if:

(i) there is doubt as to the accuracy or allowability of a significant part of the information reported;

(ii) there is reasonable doubt that a provider entity reflected economic and efficient operation due to low utilization or operation for less than a full fiscal year; or

(iii) an auditor determines that reported costs are not verifiable.

(C) When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from the database used for compilation of provider cost profiles for reasons stated in subparagraph (B)(i) and (ii) of this paragraph.

(e) Reimbursement determination. Reimbursement per hour of service is determined for each individual contracted provider by its DHS contract manager. The reimbursement determination is based upon estimated costs reported by the contracted provider for the effective reimbursement period and upon historical information reported by the contracted provider in the

form of annual cost reports covering the provider's fiscal year. Comparisons of each provider's individual cost profiles per unit of service from prior years, as well as comparisons with mean and weighted median cost profiles per unit of service across all providers, are used by the DHS contract manager in the reimbursement determination process. If cost reports covering less than a full fiscal year of operation are used in reimbursement determination, costs and other data are not annualized for purposes of determining per-unit costs and reimbursement.

(1) Cost areas. Allowable costs, reported or estimated, are combined into five cost areas, after allocating payroll taxes to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense and after applying employee benefits directly to the corresponding salary line item.

(A) Assessors of Need Cost Area. This cost area collects costs and statistics associated with assessors of need, including salaries, travel expenses, training costs, and contracted expenses.

(B) Attendant Recruitment and Orientation Cost Area. This cost area collects costs and statistics associated with persons recruiting and orienting attendants, including salaries, travel expenses, training costs, contracted expenses, and advertising costs for attendant recruitment.

(C) Attendants Cost Area. This cost area collects costs and statistics associated with regular and substitute attendants, as well as on-call staff, including salaries, travel expenses, training costs, universal health and safety costs, and other miscellaneous costs.

(D) Building and Transportation Cost Area. This cost area collects building and building equipment expenses, departmental equipment expenses, and transportation equipment expenses.

(E) Administration Cost Area. This cost area collects administrative salaries, office expenses, and central office overhead expenses.

(2) Projected costs. DHS projects allowable expenses per hour of service from each provider's reporting period to the next ensuing reimbursement period. DHS determines reasonable and appropriate economic adjusters as described in §20.108 of this title (relating to Determination of Inflation Indices) to calculate the projected expenses. DHS also adjusts reimbursement where new legislation, regulations, or economic factors affect costs as specified in §20.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).

(3) Provider cost profiles.

(A) Individual provider cost profile per unit of service. To determine a provider's individual cost profile, DHS determines a cost component for each cost area in paragraph (1)(A)-(E) of this subsection by dividing either the total reported or the total projected allowable costs for the cost area by the total units of service provided. The sum of the five cost components is the provider's individual reported or projected cost per unit of service.

(B) Mean cost profile per unit of service across all providers. To determine the mean cost profile across all providers submitting cost reports, DHS takes the results from subparagraph (A) of this paragraph for each provider and calculates a mean (average) for each cost area. The sum of the mean cost area components is the mean cost profile (reported or projected) per unit of service across all providers.

(C) Weighted median cost profile per unit of service across all providers. To determine the weighted median cost profile across all providers submitting cost reports, DHS rank-orders from low to high all providers' (reported or projected) cost per hour of service in each cost area. The hours of service for each provider that correspond with each cost array are summed until the median hour of service is reached, resulting in a weighted median cost area component. The sum of the five weighted median cost area components is the weighted median cost profile per unit of service across all providers.

(f) Reporting revenues. Revenues must be reported on the cost report in accordance with §20.104 of this title (relating to Revenues).

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 24, 1995.

TRD-9509240 Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

Earliest possible date of adoption: September 1, 1995

For further information, please call: (512) 450-3765

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# Chapter 48. Community Care for Aged and Disabled

## In-Home and Family Support Program

### • 40 TAC §48.2703, §48.2707

The Texas Department of Human Services (DHS) proposes amendments to §48. 2703 and §48.2707, concerning income eligibility and program restrictions, in its Community Care for Aged and Disabled chapter. The purpose of the amendment to §48.2703 is to revise the In-Home and Family Support Program copayment schedule based on updated state median income figures compiled by the United States Department of Health and Human Services. The purpose of the amendment to §48.2707 is to change the reference of the "Nursing Facility Waiver" program to the "Community Based Alternatives" program.

Burton F. Raiford, commissioner, has determined that for the first five-year period the sections are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the sections.

Mr. Raiford also has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be public access to correct information. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the sections as proposed.

Questions about the content of the proposal may be directed to Debbie Berliner at (512) 450-3199 in DHS's Client Eligibility section. Written comments on the proposal may be submitted to Nancy Murphy, Agency Liaison, Media and Policy Services-508, Texas Department of Human Services, E-205, P.O. Box 149030, Austin, Texas 78714-9030, within 30 days of publication in the *Texas Register*.

The amendments are proposed under the Human Resources Code, Title 2, Chapters 22 and 35, which provides the department with the authority to administer public assistance and support services for persons with disabilities programs.

The amendments implement the Human Resources Code, §§22.001-22.024 and §§35.001-35.012.

*§48.2703. Income Eligibility.*

(a)-(c) (No change.)

(d) Copayments are figured according to the following table:
Figure 1: 40 TAC §48.2703(d)
Figure 2: 40 TAC §48.2703(d)

(e)-(i) (No change.)

*§48.2707. Program Restrictions*

(a)-(g) (No change.)

(h) Individuals enrolled in the Community Living Assistance and Support Services program or the **Community Based Alternatives** [Nursing Facility Waiver] program are not eligible to receive benefits in the IH/FSP.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 26, 1995.

TRD-9509315 Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

Proposed date of adoption: October 1, 1995

For further information, please call: (512) 450-3765

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## 1915(c) Medicaid Home and Community-based Waiver Services for Aged and Disabled Adults Who Meet Criteria for Alternatives to Nursing Facility Care

• **40 TAC §48.6020, §48.6021**

The amendment and new section are proposed under the Human Resources Code, Title 2, Chapters 22 and 32, which authorizes the department to administer public and medical assistance programs; and under Texas Civil Statutes, Article 4413(502), §16, which provide the Health and Human Services Commission with the authority to administer federal medical assistance funds.

The amendment and new section implement the Human Resources Code, §§22.001-22.024 and §§32.001-32.040.

*§48.6020. Reimbursement Methodology.*

**(a) General requirements. Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §48.6021 of this title (relating to Reimbursement Methodology for 1915(c) Medicaid Home and Community-Based Waiver Services for Aged and Disabled Adults Who Meet Criteria for Alternatives to Nursing Facility Care: 1996 and Subsequent Cost Reports).**

(b)[(a)] General. The Texas Department of Human Services (DHS) will reimburse qualified Texas Medicaid contracted providers for waiver services provided to individuals who meet the criteria for alternatives to nursing facility care. Additionally, DHS will reimburse qualified Texas Medicaid contracted providers for an initial assessment of potential waiver participants. The initial assessment covers care planning for the participant and will be reimbursed by a one-time administrative expense fee which is not included in the waiver services but will be paid from Medicaid administrative funds.

[(1)] The Texas Board of Human Services (**board**) determines, for Medicaid waiver services and the one-time administrative expense fee, **reimbursements** [reimbursement rates] that are uniform, prospective, and cost-related. DHS staff submit **reimbursement** [rate] recommendations to the **board** [DHS Board].

[(2) DHS determines waiver service and the administrative expense fee rates at least annually. Rates may be determined more often if the DHS Board determines that it is necessary.]

(c)[(b)] Public **reimbursement** [rate] hearing. DHS holds a public hearing before the **board** [Texas Board of Human Services] sets **reimbursements** [payment rates]. The purpose of the hearing is to give interested persons an opportunity to comment on DHS's proposed **reimbursements** [rates]. DHS must provide notice of the hearing to the public; and at least ten working days before the hearing takes place, DHS must make material pertinent to the proposed **reimbursements** [rates] available to the public. At a minimum, this material must include DHS's proposed **reimbursements** [rates]. DHS furnishes this material to anyone who requests it from the DHS division responsible for **reimbursement** [rate] recommendations. After the hearing, DHS provides the **board** [Texas Board of Human Services] with a written summary of the comments made during the public hearing.

(d)[(c)] Waiver **reimbursement** [rate] determination methodology. The **board** [Texas Board of Human Services] determines for each waiver service and the administrative expense fee, **reimbursements** [reimbursement rates] which will reimburse the reasonable and prudent costs of a provider. Recommended **reimbursements** [rates] are determined in the following manner.

**(1) Cost data used in the determination of reimbursements, excluding depreciation and mortgage interest costs, is projected from the historical period from which it is taken to the prospective reimbursement period as described in §24.301 of this title (relating to Determination of Inflation Indices).**

(2)[(1)] Providers will be reimbursed using a method based on modeled projected expenses. Modeled projected expenses will be developed by using data from surveys; cost report data from other similar programs or services; information from professionals experienced in the delivery of similar services; and other relevant sources. The room and board payments for Adult Foster Care and Assisted Living Services are not covered in these **reimbursements** [rates] and will be paid to providers from the client's Supplemental Security Income, less a personal needs allowance.

(3)[(2)] The approved **reimbursements** [reimbursement rates] and administrative fee that are calculated will be:

(A) within budgetary constraints;

(B) adequate to reimburse the cost of operations for an efficient and economic provider; and

(C) justifiable given current economic conditions.

(4)[(3)] DHS may adjust **reimbursements** [rates] according to §24.501 of this title (relating to Adjusting Rates When New Legislation, Regulations, or Economic Factors Affect Costs) if new legislation, regulations, or economic factors affect costs.

*§48.6021. Reimbursement Methodology for 1915(c) Medicaid Home and Community-Based Waiver Services for Aged and Disabled Adults Who Meet Criteria for Alternatives to Nursing Facility Care: 1996 and Subsequent Cost Reports.*

(a) General requirements. For the completion and submittal of cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years, providers must apply the information in this section. The Texas Department of Human Services (DHS) applies the general principles of cost determination as specified in §20.101 of this title (relating to Introduction).

(b) General. DHS will reimburse qualified Texas Medicaid contracted providers for waiver services provided to individuals who meet the criteria for alternatives to nursing facility care. Additionally, DHS will reimburse qualified Texas Medicaid contracted providers for an initial assessment of potential waiver participants. The initial assessment covers care planning for the participant and will be reimbursed by a one-time administrative expense fee which is not included in the waiver services but will be paid from Medicaid administrative funds. The Texas Board of Human Services (board) determines, for Medicaid waiver services and the one-time administrative expense fee, reimbursement and reimbursement ceilings that are uniform, prospective, and cost-related. DHS staff submit reimbursement recommendations to the board.

(c) Waiver reimbursement determination methodology. DHS staff submit recommendations for each waiver service and the administrative expense fee, reimbursement and reimbursement ceilings. Recommended reimbursement is determined in the following manner.

(1) Cost data used in the determination of reimbursements, excluding depreciation and mortgage interest costs, is projected from the historical period from which it is taken to the prospective reimbursement period as described in §20.108 of this title (relating to Determination of Inflation Indices).

(2) Providers will be reimbursed using a method based on modeled projected expenses. Modeled projected expenses will be developed by using data from surveys; cost-report data from other similar programs or services; information from professionals experienced in the delivery of similar services; and other relevant sources. The room and board payments for Adult Foster Care and Assisted Living Services are not covered in the reimbursement and will be paid to providers from the client's Supplemental Security Income, less a personal needs allowance.

(3) DHS also adjusts reimbursement if new legislation, regulations, or economic factors affect costs, according to §20.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).

(d) Authority to determine reimbursement. The authority to determine reimbursement is specified in §20.101 of this title (relating to Introduction).

(e) Reporting of cost.

(1) Cost reporting guidelines. If DHS requires a cost report for any waiver services in this program, providers must follow the cost-reporting guidelines as specified in §20.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(2) Excused from submission of cost reports. If required by DHS, all contracted providers must submit a cost report unless the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer. The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost-report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any regulatory agency. Requests to be excused from submitting a cost report must be received by DHS's Rate Analysis Department before the due date of the cost report.

(3) Reporting and verification of allowable cost.

(A) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursements. DHS excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers; the purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services; and are consistent with federal and state regulations.

(B) Individual cost reports may not be included in the database used for reimbursement determination if:

(i) there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported;

(ii) there is reasonable doubt that a provider entity reflected economic and efficient operation, due to low utilization or operation for less than a full fiscal year; or

(iii) an auditor determines that reported costs are not verifiable.

(C) When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from reimbursement determination for the reasons stated in subparagraph (B)(i) and (ii) of this paragraph.

(4) Allowable and unallowable costs.

(A) Providers must follow the guidelines in determining whether a cost is allowable or unallowable as specified in §20.102 and §20.103 of this title (relating to General Principles of Allowable and Unallowable Costs, and Specifications for Allowable and Unallowable Costs), in addition to the following.

(B) Client room and board expenses are not allowable, except for those related to respite care.

(C) The actual cost of adaptive aids and home modifications are not allowable for cost reporting purposes. Allowable labor costs associated with acquiring adaptive aids and home modifications should be reported in the cost report. Any item purchased for participants in this program and reimbursed through a voucher payment system is unallowable for cost reporting purposes. Refer to §20.103(17)(K) of this title (relating to Specifications for Allowable and Unallowable Costs).

(f) Reporting revenue. Revenues must be reported on the cost report in accordance with §20.104 of this title (relating to Revenues).

(g) Reviews and field audits of cost reports. DHS staff perform desk reviews or field audits on all contracted providers. The frequency and nature of the field audit are determined by DHS staff to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §20.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and providers will be notified of the results of a desk review or a field audit in accordance with §20.107 of this title (relating to Notification of Exclusions and Adjustments). Providers may request an informal review and, if necessary, an administrative hearing to dispute an action taken by DHS under §20.110 of this title (relating to Informal Reviews and Formal Appeals).

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 24, 1995.

TRD-9509241 Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

Earliest possible date of adoption: September 1, 1995

For further information, please call: (512) 450-3765

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## Support Documents

- **40 TAC §§48.9801, 48.9802, 48.9805, 48.9806, 48.9808, 48.9809, 48.9811, 48.9812**

The amendments and new section are proposed under the Human Resources Code, Title 2, Chapters 22 and 32, which authorizes the department to administer public and medical assistance programs, and under Texas Civil Statutes, Article 4413(502), §16, which provides the Health and Human Services Commission with the authority to administer federal medical assistance funds.

The amendments and new section implement the Human Resources Code, §§22.001-22.024 and §§32.001-32.040.

*§48.9801. Reimbursement Methodology for Special Services to Persons with Disabilities-Shared Attendant Care.*

(a) Cost reporting. **Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §48.9802 of this title (relating to Reimbursement Methodology for Special Services for Handicapped Adults-Shared Attendant Care: 1996 and Subsequent Cost Reports).**

(1) Content of cost report. The contracted provider must submit financial and statistical information at least annually in a cost report prescribed by **Texas Department of Human Services (DHS)** [the department]. **All contracted providers must submit a cost report unless the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer. The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity. Requests to be excused from submitting a cost report must be received by the DHS's Rate Analysis Department before the due date of the cost report.**

(2) Cost report due date. The provider must submit the cost report no later than 90 days following receipt of the cost report forms. An extension of the due date may be granted for good cause. Good cause is that cause outside the control of the provider. The provider must submit a request in writing for an extension of the due date. **Rate Analysis Department staff respond to requests within 10 workdays of receipt.**

(3)-(7) (No change.)

(8) Failure to maintain records. A provider not maintaining adequate records to support the financial and statistical information in cost reports is given **30** [90] days to bring his record keeping into compliance. Failure to correct deficiencies within **30** [90] days from the date of notification of deficiency can result in the cancellation of the provider's contract for services.

(9)-(10) (No change.)

(b) Contract-specific unit **reimbursement** [rate].

(1) The actual **reimbursement** [rate] for each contract is determined through the procurement process with **DHS** [the department] staff and the provider.

(2) The reimbursement [rate] is on a per diem basis.

(3) The reimbursement [rate] may not exceed the average Medicaid nursing facility **reimbursement** [rate].

(c) (No change.)

**(d) Exclusion of certain reported expenses and cost reports.**

**(1) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determined recommended reimbursement. DHS excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services and consistent with federal and state regulations.**

**(2) Individual cost reports may not be included in the database used for compilation of provider cost profiles if:**

**(A) there is doubt as to the accuracy or allowability of a significant part of the information reported;**

**(B) there is reasonable doubt that a provider entity reflected economic and efficient operation due to low utilization or operation for less than a full fiscal year; or**

**(C) an auditor determines that reported costs are not verifiable.**

**(3) When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from the database used for compilation of provider cost profiles for reasons stated in paragraph (2)(A) and (B) of this subsection.**

**(e) Reimbursement determination. Reimbursement per day of service is determined for each individual contracted provider by its DHS contract manager. The reimbursement determination is based upon estimated costs reported by the contracted provider for the effective reimbursement period and upon historical information reported by the contracted provider in the form of annual cost reports covering the provider's fiscal year. Comparisons of each provider's individual cost profiles per unit of service from prior years, as well as comparisons with mean and weighted median cost profiles per unit of service across all providers, are used by the DHS contract manager in the reimbursement determination process. If cost reports covering less than a full fiscal year of operation are used in reimbursement determination, costs and other data are not annualized for purposes of determining per-unit costs and reimbursement.**

**(1) Cost areas. Allowable costs, reported or estimated, are combined into three cost areas, after allocating payroll taxes to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expenses and after applying employee benefits directly to the corresponding salary line item.**

**(A) Attendants cost area. This cost area collects costs and statistics associated with attendants, including salaries, travel expenses, and training costs.**

**(B) Facility cost area. This cost area collects building and building equipment expenses, department equipment expenses, and transportation equipment expenses.**

**(C) Administration cost area. This cost area collects administrative salaries, office expenses, and central office overhead expenses.**

**(2) Projected costs. DHS projects allowable expenses per day of service from each provider's reporting period to the next ensuing reimbursement period. DHS determines reasonable and appropriate economic adjusters to calculate the projected expenses. DHS also adjusts reimbursement where new legislation, regulations, or economic factors affect costs.**

**(3) Provider cost profiles.**

**(A) Individual provider cost profile per unit of service. To determine a provider's individual cost profile, DHS determines a cost component for each cost area in paragraph (1)(A)-(C) of this subsection by dividing either the total reported or the total projected allowable costs for the cost area by the total units of service provided. The sum of the three cost components is the provider's individual reported or projected cost per unit of service.**

**(B) Mean cost profile per unit of service across all providers. To determine the mean cost profile across all providers submitting cost reports, DHS**

**takes the results from subparagraph (A) of this paragraph for each provider and calculates a mean (average) for each cost area. The sum of the mean cost area components is the mean cost profile (reported or projected) per unit of service across all providers.**

**(C) Weighted median cost profile per unit of service across all providers. To determine the weighted median cost profile across all providers submitting cost reports, DHS rank-orders from low to high all providers' (reported or projected) cost per day of service in each cost area. The days of service for each provider that correspond with each cost array are summed until the median day of service is reached, resulting in a weighted median cost area component. The sum of the three weighted median cost area components is the weighted median cost profile per unit of service across all providers.**

(f)[(d)] Definition of reasonableness. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by an ordinarily prudent person in the conduct of competitive business. In determining the reasonableness of a given cost, the department considers the following:

(1) whether the cost is of a type generally recognized as ordinary and necessary for the operation of the business or the performance under the contract;

(2) the restraints or requirements imposed by generally accepted sound business practices, arm's length bargaining, federal and state laws and regulations, and contract terms and specifications; and

(3) the action that a prudent person would take in the circumstances, considering his responsibilities to the public, the government, his employees, clients, shareholders, or members and the fulfillment of the purpose for which the business was organized.

(g)[(e)] Unallowable costs. The following list of expenses is not intended to be inclusive of all possible unallowable costs. It is a general guide to the various unallowable costs frequently encountered in cost reports submitted by providers. Unallowable costs are expenses incurred by a provider which are not directly or indirectly related to the provision of contracted services according to applicable laws, rules, and standards. Unallowable costs are:

(1) advertising expenses except advertising for employee recruitment, and advertising to meet statutory or regulatory requirements;

(2) allowances for bad debts or other uncommon accounts;

(3) business expenses from business operations not related to the provision of services contracted for by the department;

(4) contributions to political activities or contributions to charity;

(5) discounts for administrative reasons; courtesy, cash, trade, and quantity discounts; rebates; or other discounts granted;

(6) dues and membership fees;

(7) entertainment expenses except for entertainment which is reported as an employee benefit;

(8) expenses incurred for services not related to the provision of services for which the department has contracted;

(9) expenses for purchases of goods and services from revenues received from restricted or unrestricted gifts, donations, endowments, and trusts;

(10) expenses which are not the legal obligation of the provider;

(11) expenses of donated items, including depreciation and amortization of the value of the donations;

(12) fees for corporation or association board of directors; partnership or corporation filing fees;

(13) fines and other penalties for violation of statute or ordinance; penalties for late payment of taxes, utilities, mortgages, and other similar penalties;

(14) fund-raising and promotion expenses; public relations expenses;

(15) insurance expenses for life insurance premiums if the beneficiary is the provider organization; for insurance on assets not related to the delivery of services for which the department has contracted;

(16) interest expense on loans for assets not related to the delivery of services for which the department has contracted; interest expenses must be reduced or offset by interest income except interest income from funded depreciation accounts or qualified pension funds;

(17) personal compensation paid to individuals not providing services contributory to the delivery of services for which the department has contracted;

(18) personal expenses not related to the delivery of services for which the department has contracted;

(19) expenses for the purchase of services, facilities, or supplies from related organizations or parties that exceed the lower of the cost to the related party or organization or the price of comparable services, facilities, or supplies purchased in an arm's length transaction;

(20) rental or lease expense on any item not related to the delivery of services for which the department has contracted;

(21) tax expenses for federal, state, or local income tax; any tax levied on assets not related to the delivery of services for which the department has contracted; and

(22) transportation expenses for vehicles which are not generally suited to functions related to the provision of services for which the department has contracted. Mileage expenses can be included at a cost per mile not to exceed the current reimbursement rate set by the Texas Legislature for state employee travel. Mileage is allowable if there is adequate documentation and if the expense incurred was related to the delivery of services for which the department has contracted.

*§48.9802. Reimbursement Methodology for Special Services for Handicapped Adults-Shared Attendant Care: 1996 and Subsequent Cost Reports.*

(a) General requirements. For the completion and submittal of cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years, providers must apply the information in this section. The Texas Department of Human Services (DHS) applies the general principles of cost determination as specified in §20.101 of this title (relating to Introduction).

(b) Cost reporting. Providers must follow the cost-reporting guidelines as specified in §20.105 of this title (relating to General Reporting and Documentation Requirements, Methods and Procedures). All contracted providers must submit a cost report unless the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer. The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity. Requests to be excused from submitting a cost report must be received by DHS's Rate Analysis Department before the due date of the cost report.

(c) Guidelines for desk reviews and field audits. Guidelines for desk review of cost reports are specified in §20.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports). DHS performs desk reviews or field audits on all contracted providers. The frequency and nature of the field audits are determined by DHS to ensure the fiscal integrity of the program. Providers will be

notified of the results of a desk review or field audit in accordance with §20.107 of this title (relating to Notification of Exclusions and Adjustments). Providers may request an informal review and, if necessary, an administrative hearing to dispute an action taken by DHS under §20.110 of this title (relating to Informal Reviews and Formal Appeals). The reimbursement authority is specified in §20.101 of this title (relating to Introduction).

(d) Contract-specific unit reimbursement.

(1) The actual reimbursement for each contract is determined through the procurement process with DHS staff and the provider.

(2) The reimbursement is on a per diem basis.

(3) The reimbursement may not exceed the average Medicaid nursing facility reimbursement.

(e) Factors affecting allowable costs.

(1) Providers must follow the guidelines in determining whether a cost is allowable or unallowable as specified in §20.102 of this title (relating to General Principles of Allowable and Unallowable Costs).

(2) Providers must follow the guidelines for allowable and unallowable costs as specified in §20.103 of this title (relating to Specifications for Allowable and Unallowable Costs).

(3) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determined recommended reimbursement. DHS excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services and consistent with federal and state regulations. Individual cost reports may not be included in the database used for compilation of provider cost profiles when there is doubt as to the accuracy or allowability of a significant part of the information reported; when there is reasonable doubt that a provider entity reflected economic and efficient operation and long-term viability, due to low utilization or operation for less than a full fiscal year; or when an auditor determines that reported costs are not verifiable.

(f) Reimbursement determination. Reimbursement per day of service is determined for each individual contracted provider by its DHS contract manager. The reimbursement determination is based upon estimated costs reported by the contracted provider for the effective reimbursement period and upon historical information reported by the contracted provider in the form of annual cost reports covering the provider's fiscal year. Comparisons of each provider's individual cost profiles per unit of service from prior years, as well as comparisons with mean and weighted median cost profiles per unit of service across all providers, are used by the DHS contract manager in the reimbursement determination process. If cost reports covering less than a full fiscal year of operation are used in reimbursement determination, costs and other data are not annualized for purposes of determining per-unit costs and reimbursement.

(1) Cost areas. Allowable costs, reported or estimated, are combined into three cost areas, after allocating payroll taxes to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expenses and after applying employee benefits directly to the corresponding salary line item.

(A) Attendants cost area. This cost area collects costs and statistics associated with attendants, including salaries, travel expenses, and training costs.

(B) Facility cost area. This cost area collects building and building equipment expenses, department equipment expenses, and transportation equipment expenses.

(C) Administration cost area. This cost area collects administrative salaries, office expenses, and central office overhead expenses.

(2) Projected costs. DHS projects allowable expenses per day of service from each provider's reporting period to the next ensuing reimbursement period. DHS determines reasonable and appropriate economic adjusters as described in §20.108 of this title (relating to Determination of Inflation Indices) to calculate the projected expenses. DHS also adjusts reimbursement where new legislation, regulations, or economic factors affect costs as specified in §20.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).

(3) Provider cost profiles.

(A) Individual provider cost profile per unit of service. To determine a provider's individual cost profile, DHS determines a cost component for each cost area in paragraph (1)(A)-(C) of this subsection by dividing either the total reported or the total projected allowable costs for the cost area by the total units of service provided. The sum of the three cost components is the provider's individual reported or projected cost per unit of service.

(B) Mean cost profile per unit of service across all providers. To determine the mean cost profile across all providers submitting cost reports, DHS takes the results from subparagraph (A) of this paragraph for each provider and calculates a mean (average) for each cost area. The sum of the mean cost area components is the mean cost profile (reported or projected) per unit of service across all providers.

(C) Weighted median cost profile per unit of service across all providers. To determine the weighted median cost profile across all providers submitting cost reports, DHS rank-orders from low to high all providers' (reported or projected) cost per day of service in each cost area. The days of service for each provider that correspond with each cost array are summed until the median day of service is reached, resulting in a weighted median cost area component. The sum of the three weighted median cost area components is the weighted median cost profile per unit of service across all providers.

(g) Reporting revenues. Revenues must be reported on the cost report in accordance with §20.104 of this title (relating to Revenues).

*§48.9805. Reimbursement Methodology for Congregate and Home-delivered Meals.*

(a) Reimbursement ceiling determination. When the Texas Department of Human Services (DHS) does not require a cost report, DHS staff project the reimbursement ceiling from the current reimbursement period to the next ensuing reimbursement period. DHS staff determine reasonable and appropriate economic adjusters to project the recommended reimbursement ceiling for the next reimbursement period.

(b) Reimbursement ceiling determination based on a cost-reporting process. If DHS deems it appropriate to require cost reporting, the cost reports pertaining to providers' fiscal year ending in 1995 will be governed by the information in this subsection. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §48.9806 of this title (relating to Reimbursement Methodology for Congregate and Home-Delivered Meals:

1996 and Subsequent Cost Reports). The cost-reporting process is as follows:

(1) Excused from submission of cost reports. All contracted providers must submit a cost report prescribed by the department, or on facsimiles which are formatted according to DHS specifications and are preapproved by DHS staff, unless:

(A) the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer; or

(B) a provider agency served an average of less than 500 meals a month for the designated cost report period; or

(C) circumstances beyond the control of the provider make cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity.

(2) Requests to be excused from submitting a cost report. Requests to be excused from submitting a cost report must be received by the Rate Analysis Department before the due date of the cost report.

(3) Exclusion of cost reports.

(A) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursement. DHS excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services and are consistent with federal and state regulations.

(B) Individual cost reports may not be included in the database used for reimbursement determination if:

(i) there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported;

(ii) there is reasonable doubt that a provider entity reflected economic and efficient operation due to low utilization or operation for less than a full fiscal year; or

(iii) an auditor determines that reported costs are not verifiable.

(C) When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from reimbursement determination for the reasons stated in subparagraph (B)(i) and (ii) of this paragraph.

(4) Cost-reporting requirements.

(A) Cost report due date. Provider agencies must submit cost reports no later than 90 days following receipt of the cost report forms.

(B) Extension of due date. DHS may grant extensions of due dates for good cause. A good cause is defined as one that the provider agency could not reasonably be expected to control. The provider agency must submit requests for extensions in writing to DHS before the cost report due date. Economic Analysis Division staff respond to requests within ten workdays of receipt.

(C) Reporting period. The provider agency must prepare the cost report to reflect the activities of the provider agency during its previous fiscal year. Cost reports may be required for other periods at the discretion of DHS.

(D) Failure to file an acceptable cost report. If a provider agency fails to file a cost report according to all applicable rules and instructions, DHS may withhold all vendor payments until the provider agency submits an acceptable report.

(E) Accounting requirements. The provider agency must ensure that financial and statistical information submitted in cost reports is based upon the accrual method of accounting, except for governmental institutions operated on the cash method of accounting. The provider agency's treatment of financial or statistical items must reflect the application of the generally accepted accounting principles (GAAP) approved by the American Institute of Certified Public Accountants.

(F) Allocation methods. If allocation of cost is necessary, provider agencies must use an allocation method that meets generally accepted accounting principles approved by the American Institute of Certified Public Accountants. DHS adjusts allocated costs if DHS considers the allocation method to be unreasonable. The provider agency must retain workpapers supporting allocations.

(G) Cost report certification. Provider agencies must certify the accuracy of cost reports submitted to DHS in the format specified by DHS. Provider agencies may be liable for civil and/or criminal penalties in the case of intentionally misrepresented or falsified information.

(H) Cost report supplements. DHS may at times require additional financial and statistical information other than the information contained in the cost report.

(I) Review of cost reports. DHS staff review each cost report to ensure that all financial and statistical information submitted conforms to all applicable rules and instructions. The review of the cost report includes a desk audit. If a provider agency fails to complete cost reports according to instructions or rules, DHS returns the cost reports to the provider agency for proper completion. DHS may require information other than that contained in the cost report to substantiate reported information.

(J) On-site audits. DHS may perform on-site audits on all provider agencies that participate in the program. DHS determines the frequency and nature of audits, but ensures that they are not less than that required by federal regulations relating to the administration of the program. If the provider agency fails to allow DHS to perform an audit in sufficient detail to verify reported information, DHS may withhold vendor payments.

(K) Recordkeeping requirements. Provider agencies must maintain records according to the requirements stated in §69.205 of this title (relating to Record Retention Requirements). Provider agencies must ensure that records are accurate and sufficiently detailed to support the financial and statistical information reported in cost reports.

(L) Access to records. Each provider agency or its designated agent(s) must allow access to any and all records necessary to verify information submitted to DHS on cost reports. This requirement includes records pertaining to related-party transactions and other business activities engaged in by the provider agency. If a provider agency does not allow inspection of pertinent records within 30 days following written notice from DHS, DHS places a hold on vendor payments until access to the records is allowed. If the provider agency continues to deny access to records, DHS may cancel the provider agency's contract.

(M) Failure to maintain adequate records. If a provider agency fails to maintain adequate records to support the financial and statistical information reported in cost reports, DHS allows 30 days for the provider agency to bring recordkeeping into compliance. If a provider agency fails to correct deficiencies within 30 days from the date of notification of the deficiency, DHS may cancel the provider agency's contract

(N) Amended cost report due dates. All contracted providers must submit cost reports to DHS in a manner prescribed by the department. DHS accepts amended cost reports submitted on the request of the provider until 180 days after the due date of the cost report. Since this is a prospective reimbursement system without a provision for reconciliation, amended cost reports filed after this date have no effect on the reimbursement ceiling and are not accepted.

(O) Cost of out-of-state audits. Whenever possible, the records necessary to verify information submitted to DHS on Medicaid cost reports, including related-party transactions and other business activities engaged in by the provider, must be accessible to DHS audit staff in the state of Texas. When records are not available to DHS audit staff within the state, the provider must pay the costs for DHS staff to travel and review the records out-of-state. If a provider fails to reimburse DHS for these costs within 30 days of the request for payment, DHS may request a hold be placed on the vendor payments until the costs are paid in full.

(c) Factors affecting allowable costs. This subsection applies when a cost report is required. To be allowable under this program, the provider must ensure that costs are:

(1) necessary and reasonable for the proper and efficient administration of the program to deliver services for which the department has contracted;

(2) authorized or not prohibited under state or local laws or regulations;

(3) consistent with any limitations or exclusions described in this section, federal or state laws, or other governing limitations as to types or amounts of cost items;

(4) consistent with policies, regulations, and procedures that apply uniformly to both the Congregate and Home-delivered Meals Programs and other activities of the organization of which the provider is a part;

(5) treated consistently using generally accepted accounting principles appropriate to the circumstances;

(6) not allocable to or included as a cost of any other program in either the current or a prior period; and

(7) the net of all applicable credits.

(d) Definition of reasonableness. This subsection applies when a cost report is required. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by an ordinarily prudent person in the conduct of competitive business. In determining the reasonableness of a given cost, the department considers the following:

(1) whether the cost is of a type generally recognized as ordinary and necessary for the operation of the business or the performance under the contract;

(2) the restraints or requirements imposed by generally accepted sound business practices, arm's length bargaining, federal and state laws and regulations, and contract terms and specifications; and

(3) the action that a prudent person would take in the circumstances, considering his responsibilities to the public, the government, his employees, clients, shareholders, or members, and the fulfillment of the purpose for which the business was organized.

(e) Unallowable costs. This subsection applies when a cost report is required. Unallowable costs are expenses incurred by a provider agency which are not directly or indirectly related to the provision of contracted services according to applicable laws, rules, and standards. A provider agency may expend funds on unallowable cost items, but those costs must not be included in the cost report and are not used in calculating a reimbursement ceiling recommendation. The following list is a general guide to the various unallowable costs frequently encountered in cost reports submitted by provider agencies and is not intended to be inclusive of all possible unallowable costs:

(1) advertising expenses except advertising for employee and volunteer recruitment, and advertising to meet statutory or regulatory requirements;

(2) allowances for bad debts or other uncommon accounts;

(3) business expenses not related to the provision of services for which the department has contracted;

(4) contributions to political activities or contributions to charity;

(5) discounts for administrative reasons; courtesy, cash, trade, and quantity discounts; rebates; or other discounts granted;

(6) dues and membership fees to organizations whose primary emphasis is not related to congregate or home-delivered meals services;

(7) entertainment expenses, except for entertainment which is reported as an employee benefit;

(8) expenses incurred for services not related to the provision of services for which the department has contracted;

(9) expenses which are not the legal obligation of the provider;

(10) depreciation and amortization of donated items;

(11) fees and travel expenses for corporation or association board of directors; partnership or corporation filing fees;

(12) fines and other penalties for violation of statute or ordinance; penalties for late payment of taxes, utilities, mortgages, loans and other similar penalties;

(13) fund-raising and promotion expenses; public relations expenses;

(14) expenses for life insurance premiums where the beneficiary is the provider organization unless life insurance is a requirement of a loan agreement and the loan is related to congregate or home-delivered meals;

(15) expenses for insurance on assets not related to the delivery of services for which the department has contracted;

(16) interest expense on loans for assets not related to the delivery of services for which the department has contracted; interest expenses must be reduced or offset by interest income except interest income from funded depreciation accounts or qualified pension funds;

(17) personal compensation or expenses not related to the delivery of services for which the department has contracted;

(18) expenses for the purchase of services, facilities, or supplies from related organizations or parties if the expenses exceed the lower of the cost to the related party or organization or the price of comparable services, facilities, or supplies purchased in an arm's length transaction;

(19) rental or lease expense on any item not related to the delivery of services for which the department has contracted;

(20) tax expenses for federal, state, or local income tax; any tax levied on assets not related to the delivery of services for which the department has contracted;

(21) transportation expenses for vehicles which are not generally suited to functions related to the provision of services

for which the department has contracted. Mileage expenses may be included at a cost per mile not to exceed the current reimbursement ceiling set by the legislature for state employee travel. Mileage is allowable if there is adequate documentation and if the expense incurred was related to the delivery of services for which the department has contracted;

(22) depreciation expenses other than those based on straight line depreciation; and

(23) franchise fees.

(f) Reimbursement ceiling. This subsection applies when a cost report is required. DHS staff determine the recommended reimbursement ceiling. If cost reports covering less than a full fiscal year of operation are used in reimbursement determination, costs and other data are not annualized for purposes of determining per-unit costs and reimbursement.

(1) DHS staff allocate payroll taxes and employee benefits to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense. The employee benefits for administrative staff are allocated directly to the corresponding salaries for those positions. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or social security, Workers' Compensation Insurance (WCI), Federal Unemployment Tax Act (FUTA), and Texas Unemployment Compensation Act (TUCA).

(2) DHS staff project allowable expenses from each provider agency's reporting period to the next ensuing reimbursement period. DHS determines reasonable and appropriate economic adjusters to calculate the projected expenses. Depreciation and mortgage interest expenses are not projected. DHS staff also adjust reimbursement if new legislation, regulations, or economic factors affect costs.

(3) DHS staff combine allowable reported costs into four cost areas.

(A) The administrative cost area includes administrative salaries, wages, and other administrative expenses.

(B) The facility cost area includes building and equipment expenses, and operation and maintenance expenses.

(C) The food preparation cost area includes raw food costs, salaries and wages of food service staff, and subcontracted costs when food preparation is purchased.

(D) The meal delivery cost area includes meal delivery expenses including mileage paid; meal container expenses; and vehicle rental, lease, use and/or depreciation costs.

(4) A contracted provider's projected expenses in each cost area are divided by its total units of service for the reporting period to determine the projected cost per unit of service.

(5) The contracted providers' projected costs per unit of service are ranked from low to high in each cost area.

(6) The 80th percentile cost is determined for each cost area. The recommended reimbursement ceiling is the sum of the 80th percentile costs of the four cost areas.

(g) Reimbursement determination authority. When DHS determines that a revision to the reimbursement ceiling should be established, the Texas Board of Human Services will determine the reimbursement ceiling.

(h) Contract-specific unit reimbursement. DHS determines the actual reimbursement for each contract through negotiations between DHS staff and the provider. In no instance may the negotiated unit reimbursement exceed the unit reimbursement ceiling.

*§48.9806. Reimbursement Methodology for Congregate and Home-Delivered Meals: 1996 and Subsequent Cost Reports.*

(a) Reimbursement ceiling determination. When the Texas Department of Human Services (DHS) does not require a cost report, DHS staff project the reimbursement ceiling from the current reimbursement period to the next ensuing reimbursement period. DHS staff determine reasonable and appropriate economic adjusters as described in §20.108 of this title (relating to Determination of Inflation Indices) to project the recommended reimbursement ceiling for the next reimbursement period.

(b) Reimbursement ceiling determination based on a cost-reporting process. If DHS deems it appropriate to require cost reporting, for the completion and submittal of cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years, providers must apply the information in this subsection. DHS applies the general principles of cost determination as specified in §20.101 of this title (relating to Introduction). The cost-reporting process is as follows:

(1) Documentation requirements. Providers must follow the cost-reporting guidelines specified in §20.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(2) Excused from submission of cost reports. All contracted providers must submit a cost report unless:

(A) the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer; or

(B) a provider agency served an average of less than 500 meals a month for the designated cost report period; or

(C) circumstances beyond the control of the provider make cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity.

(3) Due date requests to be excused. Requests to be excused from submitting a cost report must be received by the Rate Analysis Department before the due date of the cost report.

(4) Exclusion of cost reports.

(A) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursement. DHS excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services and are consistent with federal and state regulations.

(B) Individual cost reports may not be included in the database used for reimbursement determination if:

(i) there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported;

(ii) there is reasonable doubt that a provider entity reflected economic and efficient operation due to low utilization or operation for less than a full fiscal year; or

(iii) an auditor determines that reported costs are not verifiable.

(C) When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from reimbursement determination for the reasons stated in subparagraph (B)(i) and (ii) of this paragraph.

(5) Allowable and unallowable costs. Providers must follow the guidelines in determining whether a cost is allowable or unallowable as specified in §20.102 of this title (relating to General Principles of Allowable and Unallowable Costs). Providers must follow the guidelines for allowable and unallowable costs as specified in §20.103 of this title (relating to Specifications for Allowable and Unallowable Costs).

(6) Revenue. Revenue must be reported on the cost report according to §20.104 of this title (relating to Revenue).

(7) Review of cost reports. DHS staff perform either desk reviews or field audits on all contracted providers. The frequency and nature of the field audits are determined by DHS to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §20.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and providers will be notified of the results of a desk review or a field audit in accordance with §20.107 of this title (relating to Notification of Exclusions and Adjustments). Providers may request an informal and, if necessary, an administrative hearing to dispute an action taken by DHS under §20.110 of this title (relating to Informal Reviews and Formal Appeals).

(c) Reimbursement ceiling. This subsection applies when a cost report is required. DHS staff determine the recommended reimbursement ceiling. If cost reports covering less than a full fiscal year of operation are used in reimbursement determination, costs and other data are not annualized for purposes of determining per-unit costs and reimbursement.

(1) DHS staff allocate payroll taxes and employee benefits to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense. The employee benefits for administrative staff are allocated directly to the corresponding salaries for those positions. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or social security, Workers' Compensation Insurance (WCI), Federal Unemployment Tax Act (FUTA), and Texas Unemployment Compensation Act (TUCA).

(2) DHS staff project allowable expenses from each provider agency's reporting period to the next ensuing reimbursement period. DHS determines reasonable and appropriate economic adjusters as described in §20.108 of this title (relating to Determination of Inflation Indices) to calculate the projected expenses. Depreciation and mortgage interest expenses are not projected. DHS staff also adjust reimbursement if new legislation, regulations, or economic factors affect costs as specified in §20.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).

(3) DHS staff combine allowable reported costs into four cost areas.

(A) The administrative cost area includes administrative salaries, wages, and other administrative expenses.

(B) The facility cost area includes building and equipment expenses, and operation and maintenance expenses.

(C) The food preparation cost area includes raw food costs, salaries and wages of food service staff, and subcontracted costs when food preparation is purchased.

(D) The meal delivery cost area includes meal delivery expenses including mileage paid; meal container expenses; and vehicle rental, lease, use and/or depreciation costs.

(4) A contracted provider's projected expenses in each cost area are divided by its total units of service for the reporting period to determine the projected cost per unit of service.

(5) The contracted providers' projected costs per unit of service are ranked from low to high in each cost area.

(6) The 80th percentile cost is determined for each cost area. The recommended reimbursement ceiling is the sum of the 80th percentile costs of the four cost areas.

(d) Reimbursement determination authority. The reimbursement determination authority for this reimbursement ceiling is specified in §20. 101 of this title (relating to Introduction).

(e) Actual reimbursement. DHS determines the actual reimbursement for each contract through negotiations between DHS staff and the provider. In no instance may the negotiated unit reimbursement exceed the unit reimbursement ceiling.

*§48.9808. Reimbursement Methodology for 1915(c) of the Social Security Act Medicaid Home and Community Based Waiver Services for Persons With Related Conditions.*

**(a) General requirements. Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §48.9809 of this title (relating to Reimbursement Methodology for 1915(c) of the Social Security Act Medicaid Home and Community Based Waiver Services for Persons With Related Conditions: 1996 and Subsequent Cost Reports).**

(b)[(a)] General. The Texas Department of Human Services (DHS) will reimburse qualified providers for waiver services provided to Medicaid-eligible persons with related conditions (waiver services). "Persons with related conditions" is defined according to §27.102 of this title (relating to Definitions for Level-of-Care Criteria). [As of February 1, 1991,] DHS will reimburse qualified providers for a one-time administrative expense which covers the initial assessment and care planning for the client. This administrative expense fee is not included in the waiver services but will be paid from Medicaid administrative funds. The **Texas** [DHS] Board **of Human Services (board)** determines, for the initial assessment and care planning for waiver program applicants, an administrative expense fee that is uniform, prospective, and cost-related. The **board** [DHS Board] determines, for Medicaid waiver services, **reimbursements** [reimbursement rates] that are uniform, prospective, and cost-related. The **board** [DHS Board] determines **reimbursements** [reimbursement rates] and an administrative expense fee according to §§24.101 and 24.102 of this title (relating to General Specifications and Methodology). DHS staff submit **reimbursements** [rate] and administrative expense fee recommendations to the **board** [DHS Board].

[(b) Frequency of rate and administrative expense fee determination. DHS determines rates and the administrative expense fee at least annually. Both may be determined more often than annually if the DHS Board determines that it is necessary.]

(c) Reporting of cost.

(1) Cost report. [Each provider must submit financial and statistical information on a cost report or in a survey format designated by DHS.] **All contracted providers must submit a cost report unless the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer. A provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity. Requests to be excused from submitting a cost report must be received by the Rate Analysis Department before the due date of the cost report.** The cost report must capture

the expenses of the waiver services provided, including salaries and benefits, administration, building and equipment, utilities, supplies, travel, indirect overhead expenses related to the waiver services program. Also, the cost report must capture pertinent information related to the initial assessment and care planning process for waiver program applicants.

(A)-(G) (No change.)

(H) Record keeping requirements. Each provider must maintain records according to the requirements stated in §69.205 [§69.202] of this title (relating to Contractor's [Contractors'] Records). The provider must ensure that the records are accurate and sufficiently detailed to support the financial and statistical information reported in the cost report. If a provider does not maintain records which support the financial and statistical information submitted on the cost report, the provider will be given 30 [90] days to correct his record keeping. A hold of the vendor payments to the provider will be made if the deficiency is not corrected within 30 [90] days from the date the provider is notified.

(I) (No change.)

(2) Other sources of cost information. If DHS has determined that there is not [In the absence of] reliable cost report data from which to set waiver services unit reimbursements [rates] or the administrative expense fee, the reimbursements [rates] and/or fee will be developed by using data from surveys; cost report data from other similar programs; consultation with other service providers, associations, and professionals experienced in delivering services to persons with related conditions; and other sources.

(d) Waiver reimbursement determination methodology. If cost reports covering less than a full fiscal year of operation are used in reimbursement determination, costs and other data are not annualized for the purpose of determining per-unit costs and reimbursement.

(1) Unit of service reimbursement or reimbursement ceiling by unit of service. Reimbursement or reimbursement ceilings for related-conditions waiver services, habilitation, nursing, physical therapy, occupational therapy, speech pathology, and psychological and respite care services will be determined on a fee-for-service basis. These services are provided under the §1915(c) of the Social Security Act Medicaid waiver for persons with related conditions.

(2) Monthly reimbursement. The reimbursement for the related-conditions case management waiver service will be determined as a monthly reimbursement. This service is provided under the §1915(c) of the Social Security Act Medicaid waiver for persons with related conditions.

(3) Reporting and verification of allowable cost.

(A) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursements. DHS excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers; the purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services; and are consistent with federal and state regulations.

(B) Individual cost reports may not be included in the database used for reimbursement determination if:

*(i)* there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported;

*(ii)* there is reasonable doubt that a provider entity reflected economic and efficient operation, due to low utilization or operation for less than a full fiscal year; or

*(iii)* an auditor determines that reported costs are not verifiable.

(C) When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from reimbursement determination for the reasons stated in subparagraph (B)(i) and (ii) of this paragraph.

(4) Reimbursement determination process. DHS staff submit recommendations for reimbursements or reimbursement ceilings. Recommended unit of service reimbursements are determined in the following manner.

(A) Unit or service reimbursement for habilitation, nursing, physical therapy, occupational therapy, speech pathology, and psychological services are determined in the following manner:

*(i)* Total allowable costs for each provider will be determined by analyzing the allowable historical costs reported on the cost report and other pertinent cost survey information.

*(ii)* Total allowable costs are reduced by the amount of administrative expense fee revenues reported and any other revenues received through a voucher payment system.

*(iii)* Each provider's total allowable costs, excluding depreciation and mortgage interest, are projected from the historical cost reporting period to the prospective reimbursement period as described in §24. 301 of this title (relating to Determination of Inflation Indices).

*(iv)* Payroll taxes and employee benefits are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense for the appropriate group of staff. Employee benefits will be charged to a specific salary line item if the benefits are reported separately. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or Social Security, Medicare Contributions, Workers' Compensation Insurance (WCI), the Federal Unemployment Tax Act (FUTA), and the Texas Unemployment Compensation Act (TUCA).

*(v)* Allowable administrative, facility, and vehicle costs are allocated or spread to each waiver service cost component on a pro rata basis based on the portion of each waiver services' service units reported to the amount of total waiver service units reported.

*(vi)* An allowable cost per unit of service is calculated for each service. The allowable costs per unit of service are arrayed and weighted by the number of units of service and the median cost per unit of service is calculated.

*(vii)* The median cost per unit of service for each waiver service is multiplied by 1.044.

(B) Unit of service reimbursement and reimbursement ceilings for respite care services are determined in the following manner:

*(i)* For in-home respite care services, a unit of service reimbursement is determined using a method based on modeled projected expenses which are developed using data from surveys, cost report data from other similar programs or services, professionals' experience in delivering similar type services, and other relevant sources.

*(ii)* **For out-of-home respite care services, a unit of service reimbursement ceiling is determined using a method based on modeled projected expenses which are developed using data from surveys, cost report data from other similar programs or services, professionals' experience in delivering similar type services, and other relevant sources.**

**(C) The monthly reimbursement for case management services is determined in the following manner:**

*(i)* **Total allowable costs for each provider will be determined by analyzing the allowable historical costs reported on the cost report and other pertinent cost survey information.**

*(ii)* **Total allowable costs are reduced by the amount of administrative expense fee revenues reported.**

*(iii)* **Each provider's total allowable costs, excluding depreciation and mortgage interest, are projected from the historical cost reporting period to the prospective reimbursement period as described in §24. 301 of this title (relating to Determination of Inflation Indices).**

*(iv)* **Payroll taxes and employee benefits are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense for the appropriate group of staff. Employee benefits will be charged to a specific salary line item if the benefits are reported separately. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or social security, Medicare contributions, Workers' compensation Insurance (WCI), the Federal Unemployment Tax Act (FUTA), and the Texas Unemployment Compensation Act (TUCA).**

*(v)* **Each provider's projected total allowable costs are divided by the number of monthly units of service to determine the projected cost per client month of service.**

*(vi)* **Each provider's projected cost per client month of service is arrayed from low to high and weighted by the number of units of service, and the median cost per client month of service is calculated.**

*(vii)* **The median projected cost per client month of service is multiplied by 1.044.**

**(D) DHS also adjusts reimbursement according to §24.501 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs) if new legislation, regulations, or economic factors affect costs.**

[(d) Waiver rate determination methodology.

[(1) Rates or rate ceilings by unit of service. Reimbursement rates or rate ceilings for related-conditions waiver services, habilitation, nursing, physical therapy, occupational therapy, speech pathology, and psychological and respite care services will be determined on a fee-for-service basis. These services are provided under the §1915(c) of the Social Security Act Medicaid waiver for persons with related conditions.

[(2) Monthly rate. Effective May 1, 1994, the reimbursement rate for the related-conditions case management waiver service will be determined as a monthly rate. This service is provided under the §1915(c) of the Social Security Act Medicaid waiver for persons with related conditions.

[(3) Exclusion or adjustment of expenses. Providers must eliminate unallowable expenses from the cost report. DHS excludes from the data base any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers; the purpose is to ensure that the data base reflects costs and other information which are consistent with efficiency, economy, and quality of care; are necessary for the provision of waiver services; and are consistent with federal and state Medicaid regulations. If there is doubt as to the accuracy or allowableness of a significant part of the information reported, individual cost reports may be eliminated from the data base.

[(4) Rate determination process. The DHS Board determines, for each service, reimbursement rates or rate ceilings which will reimburse the reasonable and necessary costs of a prudent and cost-effective operation. DHS staff submit recommendations for reimbursement rates or rate ceilings. Recommended rates are determined in the following manner.

[(A) Unit or service rates for habilitation, nursing, physical therapy, occupational therapy, speech pathology and psychological services are determined in the following manner:

[(i) Total allowable costs for each provider will be determined by analyzing the allowable historical costs reported on the cost report and other pertinent cost survey information.

[(ii) Each provider's total allowable costs are projected from the historical cost reporting period to the prospective rate period as described in §24.301 of this title (relating to Determination of Inflation Indices).

[(iii) An allowable cost per unit of service is calculated for each service. The allowable costs per unit of service are arrayed and weighted by the number of units of service and the median point is calculated.

[(iv) The median cost component is multiplied by an appropriate percentage incentive factor, determined by the DHS Board, to calculate the recommended reimbursement rates

[(B) Effective with the five year renewal of the home and community based waiver for persons with related conditions, unit of service rates and rate ceilings for respite care services are determined in the following manner:

[(i) For in-home respite care services, a unit of service reimbursement rate is determined using a method based on modeled projected expenses which are developed using data from surveys, cost report data from other similar programs or services, professionals' experience in delivering similar type services, and other relevant sources.

[(ii) For out-of-home respite care services, a unit of service reimbursement rate ceiling is determined using a method based on modeled projected expenses which are developed using data from surveys, cost report data from other similar programs or services, professionals' experience in delivering similar type services, and other relevant sources.

[(C) Effective May 1, 1994, the monthly reimbursement rate for case management services is determined in the following manner:

[(i) Total allowable costs for each provider will be determined by analyzing the allowable historical costs reported on the cost report and other pertinent cost survey information.

[(ii) Each provider's total allowable costs are projected from the historical cost reporting period to the prospective rate period as described in §24.301 of this title (relating to Determination of Inflation Indices).

[(iii) Each provider's projected total allowable costs are divided by the number of client service months (total days of service participants are eligible for wavier services, divided by 30.4 days) in the provider's reporting period, to determine the projected cost per client month of service.

[(iv) Each provider's projected cost per client month of service is arrayed from low to high and a median cost per client month of service is selected.

[(v) The median projected cost per client month of service is multiplied by an appropriate percentage incentive factor, determined by the DHS Board, to calculate the recommended monthly reimbursement rate.

[(D) The Texas Board of Human Services determines reimbursement rates and rate ceilings it believes are:

[(i) within budgetary constraints;

[(ii) adequate to reimburse the reasonable and necessary costs of a prudent and cost-effective operation; and

[(iii) justifiable given current economic conditions.

[(E) DHS also adjusts rates according to §24.501 of this title (relating to Adjusting Rates When New Legislation, Regulations, or Economic Factors Affect Costs) if new legislation, regulations, or economic factors affect costs.]

**(e) Administrative expense fee determination methodology.**

**(1) One-time administrative expense fee. Reimbursement for the initial assessment and care planning process required to determine eligibility for the waiver program will be provided as a one-time administrative expense fee.**

**(2) Administrative expense fee determination process. The board determines a one-time administrative expense fee which will reimburse the costs of the reasonable and necessary costs of a prudent and cost-effective operation. DHS staff submit recommendations for an administrative expense fee reimbursement. The recommended fee is determined using a method based on modeled projected expenses which are developed using data from surveys, cost report data from other similar programs or services, professionals' experience in delivering similar services, and other relevant sources.**

[(e) Administrative expense fee determination methodology.

[(1) One-time administrative expense fee. Reimbursement for the initial assessment and care planning process required to determine eligibility for the waiver program will be provided as a one-time administrative expense fee.

[(2) Exclusion or adjustment of expenses. Providers must eliminate unallowable expenses from the cost report. DHS excludes from the data base any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the data base reflects costs and other information which are consistent with efficiency, economy, and quality of care; are necessary for the provision of the initial assessment and care planning process; and are consistent with federal and state Medicaid regulations. If there is doubt as to the accuracy or allowableness of a significant part of the information reported, individual cost reports may be eliminated from the data base.

[(3) Administrative expense fee determination process. The DHS Board determines a one-time administrative expense fee which will reimburse the costs of the reasonable and necessary costs of a prudent and cost-effective operation. DHS staff submit recommendations for an administrative expense fee reimbursement. The recommended fee is determined in the following manner.

[(A) Total number of direct service hours with the client and number of initial assessments of clients by type of professional service will be determined by analyzing allowable historical cost and other information reported on the cost report and any other pertinent cost survey information.

[(B) The number of direct service hours per initial assessment is determined by dividing, for each type of professional service, the direct service hours by the number of assessments per provider.

[(C) The number of initial assessments by type of professional service for each provider is arrayed from low to high and a weighted median is determined.

[(D) The number of direct service hours per assessment that corresponds to the weighted median number of initial assessments for that type service is selected.

[(E) The direct service hours per assessment is multiplied by the appropriate recommended reimbursement rate as described in subsection (d) of this section for that type of professional service to determine the final cost for that particular service.

[(F) Final cost for each professional service under the direct service provider will be summed to derive a final administrative expense fee for the direct service provider, and cost for the case management service will be used as the final case management administrative expense fee. These two final costs will be combined to determine one total administrative expense fee.]

**(f) Reporting requirements. The program director's full salary is to be reported on the line item of the cost report designated for the director.**

(g)[(f)] Allowable and unallowable costs.

(1) General. Allowable and unallowable costs are defined to identify expenses which are and are not reasonable and necessary to provide waiver services to clients by a prudent and cost-effective operation. Only allowable cost information is used to compile the **reimbursement determination database** [rate base]. Cost reporting by providers should be consistent with generally accepted accounting principles (GAAP). In cases where DHS cost reporting rules conflict with GAAP, IRS, or other authorities, DHS rules take precedence for cost reporting purposes.

(2) Definitions. The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

(A) Allowable costs. Those expenses that are reasonable and necessary in the normal conduct of operations relating to the provision of waiver services.

(i) "Reasonable" refers to the amount expended. The test of reasonableness is that the amount expended does not exceed the cost which would be incurred by a prudent business operator seeking to contain costs.

(ii) "Necessary" refers to the relationship of the cost to provision of waiver services. To qualify as a necessary expense, a cost must be one that is usual and customary in the operation of waiver services and must meet the following requirements.

(I) The expenditure was not for personal or other activity not specifically related to the provision of waiver services.

(II) The cost does not appear on the list of specific unallowable costs and is not unallowable under other federal, state, or local laws or regulations.

(III) The cost bears a significant relationship to the provision of waiver services. The test of significance is whether elimination of the expenditure would adversely affect the delivery of waiver services.

(IV) The expense was incurred in the purchase of materials, supplies, or services provided directly to the clients or staff of the program in the conduct of normal business operations.

(iii) Normal conduct of operations relating to waiver services and the initial assessment process includes, but is not limited to, the following:

(I) The administrative expense fee covers reimbursement for the initial assessment and care planning services.

(II) Only direct contact with the client is considered allowable when recording initial assessment and care planning time for each type of professional service.

(III) Only costs associated with the initial assessment and care planning of those clients seeking enrollment into the waiver program will be allowed.

(IV) Expenses are not used solely for the provision of waiver services and the initial assessment. Whenever allowable costs are attributable partially to personal or other business interests not related to the provision of waiver services/initial assessment and partially to waiver services/initial assessment, the latter portion may be allowed on a pro rata basis if the proportion of use by the waiver services/initial assessment is well-documented.

(V) Allowable costs must result from arms-length transactions involving unrelated parties. In related-party transactions, the allowable cost to the waiver services program is the cost to the related party. Allowable costs in this regard are limited to the lesser of the actual purchase price to the related party, or usual and customary charges for comparable goods or services. A related party is a natural person or organization related to the provider entity by blood/marriage, or common ownership, or any association which permits either entity to exert power or influence, either directly or indirectly, over the other.

(B) Unallowable costs. Those expenses that are not reasonable or necessary for the provision of waiver services and the initial assessment. Unallowable costs are not included in the data base used to determine recommended reimbursements [rates] and fees.

(3) List of Allowable Costs. The following list of allowable costs is not comprehensive, but rather serves as a general guide and identifies certain key expense areas. The absence of a particular cost does not necessarily mean that it is not an allowable cost.

(A) Compensation of waiver services staff. Compensation will be given only to those staff who provide waiver services directly to the clients or in support of staff of the waiver services in the normal conduct of operations relating to the provision of waiver services. This includes:

(i) Wages and salaries.

(ii) Payroll taxes and insurance. Federal Insurance Contributions Act (FICA or social security), unemployment compensation insurance, workman's compensation insurance.

(iii) Employee benefits. Employer-paid health, life, accident, liability, and disability insurance for employees; contributions to employee retirement fund; and deferred compensation limited to the dollar amount the employer contributes. The expense:

(I) must represent a clearly enumerated liability of the employer to individual employees;

(II) must not be incurred as a benefit to employees who do not provide services directly to the clients or staff of the waiver services program; and

(III) must not represent any form of profit sharing.

(B) Compensation of staff outside of the waiver program who provide services directly to the clients or in support of staff of the program. Allowable compensation is limited to the pro rata portion of the actual working time spent on behalf of the program.

(C) Compensation of outside consultants providing services directly to the clients or in support of staff of the program.

(D) Materials and supplies. Includes office supplies, housekeeping supplies, medical, and other supplies.

(E) Utilities. Includes electricity, natural gas, fuel oil, water, waste water, garbage collection, telephone, and telegraph.

(F) Buildings, equipment, and capital expenses. Buildings, equipment, and capital used by the waiver provider or in support of the waiver services staff, and not for personal business. If these costs are shared with other program operations, the portion of the costs relating directly to waiver services may be allowed on a pro rata basis if the proportion of use for waiver services is documented.

(G) Depreciation and amortization expense. Property owned by the provider entity and improvements to owned, leased, or rented property used by the waiver provider that are valued at more than $500 at the time of purchase must be depreciated or amortized using the straight line method. The minimum usable lives to be assigned to common classes of depreciable property are as follows:

(i) buildings: 30 years, with a minimum salvage value of 10%; and

(ii) transportation equipment used for the transport of clients, materials and supplies, or staff providing waiver services: a minimum of three years for passenger automobiles and five years for light trucks and vans, all with a minimum salvage value of 10%.

(H) Provider-owned property. Property owned by the provider entity and improvements to property owned, leased, or rented by the provider that are valued at less than $500 at the time of purchase may be treated as ordinary expenses.

(I) Rental and lease expense. This includes rental and lease expenses for buildings, building equipment, transportation equipment, and other equipment, and related materials, and supplies used by the waiver provider. Rental or lease expense paid to a related party is limited to the actual allowable cost incurred by the related party.

(J) Transportation expense. This includes the cost of public transportation or mileage claimed at the allowable reimbursement per mile set by the state legislature for state employees.

(K) Interest expense. Interest expense is allowable on loans for the acquisition of allowable items, subject to:

(i) all of the requirements for allowable costs,

(ii) written evidence of the loan, and

(iii) the provider entity being named as maker or comaker of the note. Allowable interest is limited to the lesser of the cost to the related party or the prevailing national average prime interest rate for the year in which the loan contract was executed.

(L) Tax expense. This includes real and personal property taxes, motor vehicle registration fees, sales taxes, Texas corporate franchise taxes, and organization filing fees.

(M) Insurance expense. This includes facility fire and casualty, professional liability and malpractice, and transportation insurance.

(N) Contract waiver services provided by outside vendors to persons with related conditions.

(O) Business and professional association dues limited to associations devoted primarily to the issues of related conditions.

(P) Outside training costs. Limited to direct costs (transportation, meals, lodging, and registration fees) for training provided to personnel rendering services directly to the clients or staff of the waiver provider. The training must be directly related to issues concerning related conditions and located within the continental United States.

(4) List of unallowable costs. Unallowable costs are those expenses that are not reasonable or necessary for the provision of waiver services. Unallowable costs are not included in the **reimbursement determination database** [rate base] used to determine recommended **reimbursements** [rates]. The following list is not intended to be comprehensive, but rather to serve as a general guide and identify certain key expense areas that are not allowable. The absence of a particular cost does not necessarily mean that it is an allowable cost.

(A) compensation in the form of salaries, benefits, or any form of compensation given to individuals who do not provide waiver services either directly to clients or in support of staff;

(B) personal expenses not directly related to the provision of waiver services;

(C) client room and board expenses, except for those related to respite care;

(D) management fees paid to a related party that are not derived from the actual cost of materials, supplies, or services provided directly to the program;

(E) advertising expenses other than those for yellow pages advertising, advertising for employee recruitment, and advertising to meet any statutory or regulatory requirement;

(F) business expenses not directly related to the provision of waiver services;

(G) political contributions;

(H) depreciation and amortization of unallowable costs. This includes amounts in excess of those resulting from the straight line depreciation method, capitalized lease expenses in excess of the actual lease payment, and goodwill or any excess above the actual value of the physical assets at the time of purchase;

(I) trade discounts of all types. Returns, allowances, and refunds;

(J) donated facilities, materials, supplies, and services including the values assigned to the services of unpaid workers and volunteers;

(K) dues to all types of political and social organizations, and to professional associations not directly and primarily concerned with the provision of waiver services;

(L) entertainment expenses except those incurred for entertainment provided to the staff of the waiver provider as an employee benefit;

(M) Boards of directors' fees;

(N) fines and penalties for violations of regulations, statutes, and ordinances of all types;

(O) fund raising and promotional expenses;

(P) expenses incurred in the purchase of goods and services with revenues from gifts, donations, endowments, and trusts;

(Q) interest expenses on loans pertaining to unallowable items and on that portion of interest paid which is reduced or offset by interest income;

(R) insurance premiums pertaining to items of unallowable cost;

(S) accrued expenses that are not a legal obligation of the provider or are not clearly enumerated as to dollar amount. This includes any form of profit sharing and the accrued liabilities of deferred compensation plans;

(T) planning and evaluation expenses for the purchase of depreciable assets, except where purchases are actually made and the assets are put into service in providing waiver services;

(U) mileage expense which exceeds the current reimbursement rate set by the Texas Legislature for state employee travel or expenses exceeding actual cost of public transportation;

(V) costs of purchases from a related party which exceed the original cost to the related party;

(W) out-of-state travel expenses, except for provision of waiver services that may include training and quality assurance functions;

(X) legal and other costs associated with litigation between a provider and state or federal agencies, unless the litigation is decided in the provider's favor;

(Y) contributions to self-insurance funds which do not represent payments based on current liabilities;

(Z) any expense incurred because of imprudent business practices;

(AA) expenses which cannot be adequately documented;

(BB) expenses not reported according to the instructions on the cost report;

(CC) expenses not allowable under other pertinent federal, state, or local laws and regulations; and

(DD) federal, state, and local income taxes and any expenses related to preparing and filing income tax forms.

*§48.9809. Reimbursement Methodology for 1915(c) of the Social Security Act Medicaid Home and Community Based Waiver Services for Persons With Related Conditions: 1996 and Subsequent Cost Reports.*

(a) General requirements. For the completion and submittal of cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years, providers must apply the information in this section. The Texas Department of Human Services (DHS) applies the general principles of cost determination as specified in §20.101 of this title (relating to Introduction).

(b) General. DHS will reimburse qualified providers for waiver services provided to Medicaid-eligible persons with related conditions (waiver services) . "Persons with related conditions" is defined according to §27.102 of this title (relating to Definitions for Level-of-Care Criteria). Also, DHS will reimburse qualified providers for a one-time administrative expense which covers the initial assessment and care planning for the client. This administrative expense fee is not included in the waiver services but will be paid from Medicaid administrative funds. The Texas Board of Human Services (board) determines, for the initial assessment and care planning for waiver program applicants, an administrative expense fee that is uniform, prospective, and cost-related. The board determines, for Medicaid waiver services, unit of service reimbursement and reimbursement ceilings that are uniform, prospective, and cost-related.

(c) Reporting of cost.

(1) Providers must follow the cost reporting guidelines as specified in §20.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(2) All contracted providers must submit a cost report unless the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer.

(3) A provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity. Requests to be excused from submitting a cost report must be received by the Rate Analysis Department before the due date of the cost report.

(d) Waiver reimbursement determination methodology. If cost reports covering less than a full fiscal year of operation are used in reimbursement determination, costs and other data are not annualized for the purpose of determining per-unit costs and reimbursement.

(1) Unit of service reimbursement or reimbursement ceiling by unit of service. Reimbursement or reimbursement ceilings for related-conditions waiver services, habilitation, nursing, physical therapy, occupational therapy, speech pathology, and psychological and respite care services will be determined on a fee-for-service basis. These services are provided under the §1915(c) of the Social Security Act Medicaid waiver for persons with related conditions.

(2) Monthly reimbursement. The reimbursement for the related-conditions case management waiver service will be determined as a monthly reimbursement. This service is provided under the §1915(c) of the Social Security Act Medicaid waiver for persons with related conditions.

(3) Reporting and verification of allowable cost.

(A) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursements. DHS excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers; the purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services; and are consistent with federal and state regulations.

(B) Individual cost reports may not be included in the database used for reimbursement determination if:

(i) there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported;

(ii) there is reasonable doubt that a provider entity reflected economic and efficient operation, due to low utilization or operation for less than a full fiscal year; or

(iii) an auditor determines that reported costs are not verifiable.

(C) When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from reimbursement determination for the reasons stated in subparagraph (B)(i) and (ii) of this paragraph.

(4) Reimbursement determination process. DHS staff submit recommendations for unit of service reimbursement or reimbursement ceilings. Recommended unit of service reimbursements are determined in the following manner.

(A) Unit or service reimbursement for habilitation, nursing, physical therapy, occupational therapy, speech pathology, and psychological services are determined in the following manner:

(i) Total allowable costs for each provider will be determined by analyzing the allowable historical costs reported on the cost report and other pertinent cost survey information.

(ii) Total allowable costs are reduced by the amount of administrative expense fee revenues reported and any other revenues received through a voucher payment system.

(iii) Each provider's total allowable costs, excluding depreciation and mortgage interest, are projected from the historical cost reporting period to the prospective reimbursement period as described in §20.108 of this title (relating to Determination of Inflation Indices).

(iv) Payroll taxes and employee benefits are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense for the appropriate group of staff. Employee benefits will be charged to a specific salary line item if the benefits are reported separately. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or Social Security, Medicare Contributions, Workers' Compensation Insurance (WCI), the Federal Unemployment Tax Act (FUTA), and the Texas Unemployment Compensation Act (TUCA).

(v) Allowable administrative, facility, and vehicle costs are allocated or spread to each waiver service cost component on a pro rata basis based on the portion of each waiver services' service units reported to the amount of total waiver service units reported.

(vi) An allowable cost per unit of service is calculated for each service. The allowable costs per unit of service are arrayed and weighted by the number of units of service and the median cost per unit of service is calculated.

(vii) The median cost per unit of service for each waiver service is multiplied by 1.044.

(B) Unit of service reimbursement and reimbursement ceilings for respite care services are determined in the following manner:

(i) For in-home respite care services, a unit of service reimbursement is determined using a method based on modeled projected expenses which are developed using data from surveys, cost

report data from other similar programs or services, professionals' experience in delivering similar type services, and other relevant sources.

(ii) For out-of-home respite care services, a unit of service reimbursement ceiling is determined using a method based on modeled projected expenses which are developed using data from surveys, cost report data from other similar programs or services, professionals' experience in delivering similar type services, and other relevant sources.

(C) The monthly reimbursement for case management services is determined in the following manner:

(i) Total allowable costs for each provider will be determined by analyzing the allowable historical costs reported on the cost report and other pertinent cost survey information.

(ii) Total allowable costs are reduced by the amount of administrative expense fee revenues reported.

(iii) Each provider's total allowable costs, excluding depreciation and mortgage interest, are projected from the historical cost reporting period to the prospective reimbursement period as described in §20.108 of this title (relating to Determination of Inflation Indices).

(iv) Payroll taxes and employee benefits are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense for the appropriate group of staff. Employee benefits will be charged to a specific salary line item if the benefits are reported separately. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or social security, Medicare contributions, Workers' compensation Insurance (WCI), the Federal Unemployment Tax Act (FUTA), and the Texas Unemployment Compensation Act (TUCA).

(v) Each provider's projected total allowable costs are divided by the number of monthly units of service to determine the projected cost per client month of service.

(vi) Each provider's projected cost per client month of service is arrayed from low to high and weighted by the number of units of service and the median cost per client month of service is calculated.

(vii) The median projected cost per client month of service is multiplied by 1.044.

(D) DHS also adjusts reimbursement according to §20.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs) if new legislation, regulations, or economic factors affect costs.

(e) Administrative expense fee determination methodology.

(1) One-time administrative expense fee. Reimbursement for the initial assessment and care planning process required to determine eligibility for the waiver program will be provided as a one-time administrative expense fee.

(2) Administrative expense fee determination process. The board determines a one-time administrative expense fee which will reimburse the costs of the reasonable and necessary costs of a prudent and cost-effective operation. DHS staff submit recommendations for an administrative expense fee reimbursement. The recommended fee is determined using a method based on modeled projected expenses which are developed using data from surveys, cost report data from other similar programs or services, professionals' experience in delivering similar services, and other relevant sources.

(f) Allowable and unallowable costs.

(1) Providers must follow the guidelines in determining whether a cost is allowable or unallowable as specified in §20.102 and §20.103 of this title (relating to General Principles of Allowable and Unallowable Costs, and Specifications for Allowable and Unallowable Costs) as well as the following provisions.

(2) Participant room and board expenses are not allowable, except for those related to respite care.

(3) The cost of adaptive aids and home modifications are not allowable. Allowable labor costs associated with acquiring adaptive aids and home modifications should be reported in the cost report. Any item purchased for participants in this program and reimbursed through a voucher payment system is unallowable. Refer to §20.103(17)(K) of this title (relating to Specifications for Allowable and Unallowable Costs).

(g) Authority to determine reimbursement. The authority to determine reimbursement is specified in §20.101 of this title (relating to Introduction).

(h) Reporting revenue. Revenues must be reported on the cost report in accordance with §20.104 of this title (relating to Revenues).

(i) Reviews and field audits of cost reports. DHS staff perform desk reviews or field audits on all contracted providers. The frequency and nature of the field audit are determined by DHS to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §20.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and providers will be notified of the results of a desk review or an field audit in accordance with §20.107 of this title (relating to Notification of Exclusions and Adjustments). Providers may request an informal review and, if necessary, an administrative hearing to dispute an action taken by DHS under §20.110 of this title (relating to Informal Reviews and Formal Appeals).

(j) Reporting requirements. The program director's full salary is to be reported on the line item of the cost report designated for the director.

*§48.9811. Reimbursement Methodology for the Medically Dependent Children Program, a 1915(c) Home and Community Based Waiver Program.*

**(a) General requirements. Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §48.9812 of this title (relating to Reimbursement Methodology for the Medically Dependent Children Program, a 1915(c) Home and Community-Based Waiver Program: 1996 and Subsequent Cost Reports).**

(b)[(a)] General. For services provided on and after August 1, 1993, the Texas Department of Human Services (DHS) reimburses qualified providers for waiver services provided to qualified children who, if they did not receive the services, would require nursing facility care.

[(1)] The Texas Board of Human Services **(board)** determines **reimbursements** [reimbursement rates] and **reimbursement** [rate] ceilings for Medicaid waiver services, based on DHS staff recommendations, which are uniform, prospective, and cost related.

[(2) DHS determines waiver service rates and rate ceilings at least annually. Rates and rate ceilings may be determined more often if the Texas Board of Human Services determines that it is necessary.]

(c)[(b)] Public **reimbursement** [Rate] hearing. DHS holds a public hearing before the **board** [Texas Board of Human Services] sets payment **reimbursements** [rates] and **reimbursement** [rate] ceilings. The purpose of the hearing is to give interested persons an opportunity to comment on DHS's proposed **reimbursements** [rates]. DHS provides notice of the hearing to the

public; and at least 10 workdays before the hearing takes place, DHS makes material pertinent to the proposed **reimbursements** [rates] and **reimbursement** [rate] ceilings available to the public. DHS furnishes this material to anyone who requests it from the DHS department responsible for **reimbursement** [rate] recommendations. After the hearing, DHS provides the **board** [Texas Board of Human Services] with a written summary of the comments made during the public hearing.

(d)[(c)] Waiver **reimbursement** [Rate] and **reimbursement** [Rate] ceiling determination methodology. The Texas Board of Human Services determines for each waiver service, **reimbursements** [rates] and **reimbursement** [rate] ceilings which will reimburse the reasonable and necessary costs of a prudent and cost-effective operation. Recommended **reimbursements** [rates] and **reimbursement** [rate] ceilings are determined in the following manner:

**(1) Cost data used in the determination of reimbursement, excluding depreciation and mortgage interest costs, are projected from the historical period from which it is taken to the prospective reimbursement period as described in §24.301 of this title (relating to Determination of Inflation Indices).**

(2)[(1)] For facility-based respite services, providers are reimbursed an amount equal to the approved reimbursement [rate] associated with the nursing facility Texas Index for Level of Effort (TILE) category determined for the waiver client.

(3)[(2)] For nursing services, a recommended **reimbursement** [rate] ceiling is determined using a method based on modeled projected expenses, as follows:

(A) Modeled projected expenses are developed using data from surveys, cost-report data from other similar programs or services, professionals' experience in delivering similar type services, and other relevant sources.

(B) Contract-specific unit reimbursements are determined through negotiations between DHS staff and providers of nursing services. The negotiated unit reimbursement may not exceed the unit reimbursement ceiling set by the **board** [Texas Board of Human Services].

(4)[(3)] The **board** [Texas Board of Human Services] determines **reimbursements** [reimbursement rates] and **reimbursement** [rate] ceilings it believes are:

(A) within budgetary constraints;

(B) sufficient to reimburse the reasonable and necessary costs of a prudent and cost-effective operation; and

(C) justifiable, given current economic conditions.

(5)[(4)] DHS may adjust **reimbursements** [rates] and **reimbursement** [rate] ceilings according to §24.501 of this title (relating to Adjusting Rates When New Legislation, Regulations, or Economic Factors Affect Costs) if new legislation, regulations, or economic factors affect costs.

*§48.9812. Reimbursement Methodology for the Medically Dependent Children Program, a 1915(c) Home and Community-Based Waiver Program: 1996 and Subsequent Cost Reports.*

(a) General requirements. For the completion and submittal of cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years, providers must apply the information in this section. The Texas Department of Human Services (DHS) applies the general principles of cost determination as specified in §20.101 of this title (relating to Introduction).

(b) General. DHS reimburses qualified Texas Medicaid contracted providers for waiver services provided to qualified children who, if they did not receive the services, would require nursing facility care. The Texas Board of Human Services (board) determines reimbursement and reimbursement ceilings for Medicaid waiver services, based on DHS staff recommendations, which are uniform, prospective, and cost-related.

(c) Waiver reimbursement and reimbursement ceiling determination methodology. Recommended reimbursement and reimbursement ceilings are determined in the following manner.

(1) Cost data used in the determination of reimbursement, excluding depreciation and mortgage interest costs, are projected from the historical period from which it is taken to the prospective reimbursement period as described in §20.108 of this title (relating to Determination of Inflation Indices).

(2) For facility-based respite services, providers are reimbursed an amount equal to the approved reimbursement associated with the nursing facility Texas Index for Level of Effort (TILE) category determined for the waiver client.

(3) For nursing services, a recommended ceiling is determined using a method based on modeled projected expenses, as follows.

(A) Modeled projected expenses are developed using data from surveys, cost-report data from other similar programs or services, professionals' experience in delivering similar type services, and other relevant sources.

(B) Contract-specific unit reimbursement is determined through negotiations between DHS staff and providers of nursing services. The negotiated unit reimbursement may not exceed the unit reimbursement ceiling set by the board.

(4) DHS also adjusts reimbursement when new legislation, regulations, or economic factors affect costs according to §20.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulation, or Economic Factors Affect Costs).

(d) Authority to determine reimbursement. The authority to determine reimbursement is specified in §20.101 of this title (relating to Introduction).

**This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.**

**Issued in Austin, Texas, on July 24, 1995.**

TRD-9509242

**Nancy Murphy**
**Section Manager, Media and Policy Services**
**Texas Department of Human Services**

**Earliest possible date of adoption: September 1, 1995**

**For further information, please call: (512) 450-3765**

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## • 40 TAC §48.9805

*(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Department of Human Services or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)*

**The repeal is proposed under the Human Resources Code, Title 2, Chapter 22, which authorizes the department to administer public assistance programs.**

**The repeal implements the Human Resources Code, §§22.001-22.024.**

*§48.9805. Reimbursement Methodology for Congregate and Home-delivered Meals.*

**This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.**

**Issued in Austin, Texas, on July 24, 1995.**

TRD-9509243

**Nancy Murphy**
**Section Manager, Media and Policy Services**
**Texas Department of Human Services**

Earliest possible date of adoption: September 1, 1995

For further information, please call: (512) 450-3765

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## Chapter 50. Day Activity and Health Services

The Texas Department of Human Services (DHS) proposes the repeal of §50. 6903, amendments to §§50.6901, 50.6902, and 50.6904-50.6906, and new §50. 6903 and §50.6907, concerning reimbursement methodology, in its Day Activity and Health Services chapter. The purpose of the proposal is to clarify current reimbursement methodology practice, incorporate cost report procedural changes and remove the occupancy rate adjustment. The purpose of the new §50.6907 is also to establish cost determination rules that are consistent across programs, provide explicit guidelines for auditors, provide specific instructions concerning cost reporting, and provide guidelines in areas such as documentation and allocation methods.

These sections were proposed in the December 30, 1994, issue of the *Texas Register* and withdrawn on June 27, 1995. The current proposal includes the original proposal as revised in response to public comments received during that publication process.

Also in this issue of the *Texas Register*, DHS is proposing new Chapter 20 and related policies in Chapters 19, 24, 46, 47, 48, and 52 of this title.

Burton F. Raiford, commissioner, has determined that for the first five-year period the sections are in effect there will be fiscal implications for state government as a result of enforcing or administering the sections. The effect on state government for the first five-year period the sections will be in effect is an estimated additional cost of $70,501 in Fiscal Year 1996, $86,901 in Fiscal Year 1997, $96,365 in Fiscal Year 1998, $105,829 in Fiscal Year 1999, and $115,292 in Fiscal Year 2000. There will be no fiscal implications for local government.

Mr. Raiford also has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be a single set of guidelines to facilitate financial accountability relating to service delivery and a better understanding of the reimbursement methodology due to inclusion of additional detail. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the proposed sections.

A public hearing will be held at 3:00 p.m. on August 16, 1995, in the Texas Department of Mental Health and Mental Retardation Central Office auditorium at 909 West 45th Street in Austin.

Questions about the content of this proposal may be directed to Carolyn Pratt at (512) 450-4057 in DHS's Rate Analysis Department. Written comments on the proposal may be submitted to Nancy Murphy, Media and Policy Services-177, Texas Department of Human Services E-205, P.O. Box 149030, Austin, Texas 78714-9030, within 30 days of publication in the *Texas Register*. Contact Kathy Hall in Austin at (512) 450-3702, or a local DHS office, for copies of the proposed rules.

## Reimbursement Methodology for Day Activity and Health Services

### • 40 TAC §§50.6901-50.6907

The amendments and new sections are proposed under the Human Resources Code, Title 2, Chapters 22 and 32, which authorizes the department to administer public and medical assistance programs; and under Texas Civil Statutes, Article 4413(502), §16, which provide the Health and Human Services Commission with the authority to administer federal medical assistance funds.

The amendments and new sections implement the Human Resources Code, §§22. 001-22.024 and §§32.001-32.040.

*§50.6901. Introduction.* **Day** [Adult day] activity and health care facilities provide noninstitutional care to clients residing in the community through rehabilitative nursing and social services. The Texas Department of Human Services (DHS) reimburses Day Activity and Health Services provider agencies for the services they provide to clients.

*§50.6902. Cost Reporting Procedures.*

**(a) Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §50.6907 of this title (relating to Reimbursement Methodology for Day Activity and Health Services: 1996 and Subsequent Cost Reports).**

(b) Provider agencies must submit financial and statistical information at least annually on cost report forms provided by the Texas Department of Human Services (DHS) or on facsimiles which are formatted according to DHS specifications and are preapproved by DHS staff. Providers must complete the cost report according to the rules and specifications set forth in this section. The Texas Board of Human Services determines reimbursement [rates] as specified in §24.101 and §24.102 of this title (relating to General Specifications and Methodology).

(1) Cost report due date. Provider agencies must submit cost reports to DHS no later than 90 days following receipt of the cost report forms.

(2) Extension of due date. DHS may grant extensions of due dates for good cause. A good cause is defined as one that the provider agency could not reasonably be expected to control. Provider agencies must submit requests for extensions in writing to DHS before the cost report due date. **Rate Analysis Department** [Provider Reimbursement Section] staff respond to requests within ten workdays of receipt.

(3) Reporting period. The provider agency must prepare the cost report to reflect the activities of the provider agency during the previous fiscal year. Cost reports may be required for other periods at the discretion of the department. Should a provider agency terminate its contract (provider agreement) with the department, a cost report must be submitted for that period beginning with the first day not included in a previous cost reporting period and ending with the effective date of termination of its provider agreement.

(4) Failure to file an acceptable cost report. If a provider agency fails to file a cost report or cost report supplement according to all applicable rules and instructions, the department may withhold all provider payments until the provider agency submits an acceptable cost report.

(5) Accounting requirements. The provider agency must ensure that financial and statistical information submitted in cost reports is based upon the accrual method of accounting, except for governmental institutions operated on the cash method of accounting. The provider agency's treatment of any financial or statistical item must reflect the application of the generally accepted accounting principles (GAAP) approved by the American Institute of Certified Public Accountants.

(6) Allocation method. If allocation of cost is necessary, provider agencies must use reasonable methods of allocation. DHS adjusts allocated costs if the department considers the allocation method to be unreasonable. The provider agency must retain workpapers supporting allocations.

(7) Cost report certification. Provider agencies must certify the accuracy of cost reports submitted to DHS in the format specified by DHS. Provider agencies may be liable for civil and/or criminal penalties in the case of misrepresented or falsified information.

(8) Cost report supplements. The department may at times require additional financial and statistical information other than the information contained in the cost report.

(9) Review of cost reports. DHS staff review each cost report to ensure that all financial and statistical information sub-

mitted conforms to all applicable rules and instructions. The review of the cost report includes a desk audit. DHS reviews all cost reports according to the criteria in §24.201 of this title (relating to Basic Objectives and Criteria for Desk Review of Cost Reports). If a provider agency fails to complete cost reports according to instructions or rules, the department returns the cost reports to the provider agency for proper completion. The department may require information other than that contained in the cost report to substantiate reported information

(10) On-site audits. The department may perform on-site audits on all provider agencies that participate in the program. DHS determines the frequency and nature of audits but ensures that they are not less than that required by federal regulations related to the administration of the program.

(11) Notification of exclusions and adjustments. DHS notifies providers of exclusions and adjustments to reported expenses made during desk reviews and on-site audits of cost reports as specified in §24.401 of this title (relating to Notification).

(12) Access to records. Each provider agency or its designated agent(s) must allow access to any and all records necessary to verify information submitted to DHS on cost reports. This requirement includes records pertaining to related-party transactions and other business activities engaged in by the provider agency. If a provider agency does not allow inspection of pertinent records within 30 days following written notice from DHS, a hold is placed on vendor payments until access to the records is allowed. If the provider agency continues to deny access to records, the department may cancel the provider agency's contract.

(13) Recordkeeping requirements. Provider agencies must maintain records according to the requirements stated in §69.205 [§69.202] of this title (relating to Contractor's [Contractors'] Records). Provider agencies must ensure that records are accurate and sufficiently detailed to support the financial and statistical information contained in cost reports.

(14) Failure to maintain adequate records. If a provider agency fails to maintain adequate records to support the financial and statistical information reported in cost reports, the department allows 90 days for the provider agency to bring recordkeeping into compliance. If a provider agency fails to correct deficiencies within 90 days from the date of notification of the deficiency, the department may cancel the provider agency's contract for services.

*§50.6903. Reimbursement Determination.*

(a) General requirements. Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §50.6907 of this title (relating to Reimbursement Methodology for Day Activity and Health Services: 1996 and Subsequent Cost Reports).

(b) Exclusion of cost reports.

(1) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursement. The Texas Department of Human Services (DHS) excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services and are consistent with federal and state regulations.

(2) Individual cost reports may not be included in the database used for reimbursement determination if:

(A) there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported;

(B) there is reasonable doubt that a provider entity reflected economic and efficient operation due to low utilization or operation for less than a full fiscal year; or

(C) an auditor determines that reported costs are not verifiable.

(3) When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from reimbursement determination for the reasons stated in paragraph (2)(A) and (B) of this subsection.

(c) Reimbursement determination. DHS determines reimbursement in the following manner. If cost reports covering less than a full fiscal year of operation are used in reimbursement determination, costs and other data are not annualized for purposes of determining per-unit costs and reimbursement.

(1) All contracted providers must submit a cost report unless the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer. The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity. Requests to be excused from submitting a cost report must be received by the DHS's Rate Analysis Department before the due date of the cost report.

(2) A provider agency may request notification of the exclusions and adjustments to reported expenses made during either desk reviews or on-site audits according to §24.401 of this title (relating to Notification). Providers may request an informal review and, if necessary, an administrative hearing to dispute an action taken by DHS under §24.601 of this title (relating to Reviews and Administrative Hearings).

(3) DHS staff allocate payroll taxes and employee benefits to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense. The employee benefits for administrative staff are allocated directly to the corresponding salaries for those positions. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or Social Security, Workers' Compensation Insurance (WCI), Federal Unemployment Tax Act (FUTA), and the Texas Unemployment Compensation Act (TUCA).

(4) DHS staff project all allowable expenses for the period from each provider's reporting period to the next ensuing reimbursement period. DHS staff determine reasonable and appropriate economic adjusters as described in §24.301 of this title (relating to Determination of Inflation Indices) to calculate the projected expenses. Depreciation and mortgage interest expenses are not projected. DHS staff also adjust reimbursement if new legislation, regulations, or economic factors affect costs as specified in §24.501 of this title (relating to Adjusting Rates When New Legislation, Regulations, or Economic Factors Affect Costs).

(5) DHS staff combine allowable reported costs into the following six cost areas.

(A) Salaries and benefits cost area includes the salaries, wages, payroll taxes, and benefits of Day Activity and Health Services personnel, excluding dieticians, food servers, and administrative staff.

(B) Transportation cost area includes the rental or lease of transportation equipment and operating costs. The driver's salary is not included in this cost area.

(C) Food and food service cost area includes the cost of meals, related supplies, dieticians, and food servers.

(D) Building, equipment, and capital cost area includes all building operation expenses.

(E) Utility cost area includes all water, electric, gas, and telephone expenses.

(F) Direct programmatic expenses cost area includes the costs of medical and activity supplies, and administration, including administrative staff.

(6) Allowable costs are totaled by cost area and then divided by the total units of service for the reporting period to determine the cost per unit of service. DHS staff rank from low to high all provider agencies' projected costs per unit of service in each cost area. The median projected unit of service cost from each cost area is then determined The median unit of service cost is multiplied by 1.044 and the resulting cost area amounts are then totaled to become the recommended reimbursement.

(d) Reimbursement determination authority. The Texas Board of Human Services establishes reimbursement using the Medicaid state plan and state rules, the provisions of which are included in this chapter. Reimbursement is set in an open meeting after Board consideration of financial and statistical information, and public testimony.

*§50.6904. Allowable Cost Information.*

**(a) General requirements. Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §50.6907 of this title (relating to Reimbursement Methodology for Day Activity and Health Services: 1996 and Subsequent Cost Reports).**

(b)[(a)] Factors affecting allowable costs. To be allowable under this program, costs must be:

(1) necessary and reasonable for the proper and efficient administration of the program to deliver services for which the department has contracted;

(2) authorized or not prohibited under state or local laws or regulations;

(3) consistent with any limitations or exclusions described in this section, federal or state laws or other governing limitations as to types or amounts of cost items:

(4) consistent with policies, regulations, and procedures that apply uniformly to both the Day Activity and Health Services Program and other activities of the organization of which the provider agency is a part,

(5) treated consistently using generally accepted accounting principles appropriate to the circumstances;

(6) not allocable to or included as a cost of any other program in either the current or a prior period; and

(7) the net of all applicable credits.

(c)[(b)] Definition of reasonableness. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by an ordinarily prudent person in the conduct of competitive business. In determining the reasonableness of a given cost, the department considers the following:

(1) whether the cost is of a type generally recognized as ordinary and necessary for the operation of the business or the performance under the contract;

(2) the restraints or requirements imposed by generally accepted sound business practices, arm's length bargaining, federal and state laws and regulations, and contract terms and specifications; and

(3) the action that a prudent person would take in the circumstances, considering his responsibilities to the public, the government, his employees, clients, share-holders, or members, and the fulfillment of the purpose for which the business was organized.

*§50.6905. List of Allowable Costs.*

**(a) Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §50.6907 of this title (relating to Reimbursement Methodology for Day Activity and Health Services: 1996 and Subsequent Cost Reports).**

**(b)** The following list of allowable costs is not comprehensive, but rather serves as a general guide, and serves to clarify certain key expense areas. The absence of a particular cost does not necessarily mean that it is not an allowable cost.

(1) Compensation of **Day Activity and Health Services (DAHS)** [DAHS] employees. Only those employees who provide services directly to **DAHS** [Day Activity and Health Services] participants, such as the director, social service activities coordinator, registered nurse, vocational nurse, attendant, driver, and food service personnel receive compensation, which includes:

(A) wages and salaries. This can include deferred compensation, overtime pay, incentive pay and bonuses or any other monies subject to withholding taxes and **Federal Insurance Contributions Act (FICA)** [FICA] deductions.

(B) payroll taxes and insurance. This includes Federal Insurance Contributions Act (FICA or social security), unemployment compensation insurance, workmen's compensation insurance.

(C) employee benefits. This includes employer paid health and life insurance premiums, disability insurance for employees, employer contributions to employee retirement accounts, uniform/clothing allowances, and meals provided to employees as part of an employment contract.

(2) Transportation. Expenses must be directly related to the provision of transportation services for DAHS recipients. These expenses include the rental, lease, or contract costs of transportation equipment, depreciation, and operating/maintenance costs. Mileage is allowable if there is adequate documentation of the mileage and if the expense was related to delivery of services for which the department has contracted.

(3) Food and food services. Cost of meals and snacks must be for participants in the DAHS program only. This includes food and nonalcoholic beverages, food service supplies, and cooking utensils expenses.

(4) Medical equipment and supplies. These are allowable costs if they are related to the services for which the department has contracted. This may include, but is not limited to, supplies and equipment considered necessary to perform client assessments, medication administration, and nursing treatment.

(5) Building, equipment and capital expenses.

(A) Depreciation and amortization expense. Property owned by the provider and improvements to owned, leased, or rented property valued at more than $500 at the time of purchase must be depreciated

or amortized, using the straight-line method.

(i) Buildings. Allowable depreciation is calculated by deducting the estimated salvage value from the historical cost and dividing the result by the asset's remaining years of useful life.

(ii) Building equipment. Allowable items for depreciation include air conditioning units, trade fixtures, furnaces, chairs, tables, beds, building and grounds improvements.

(B) Rental and lease expense. Rental and lease expense paid to a related party is limited to the lower one of these two costs: the actual cost to the related party or the actual cost if rented or purchased elsewhere. This includes buildings, building equipment, and furniture.

(C) Interest expense.

(i) Interest expense is allowable on loans for the acquisition of allowable items, subject to all of the requirements for allowable costs and the following:

(I) the loan must be evidenced in writing; and

(II) the loan must be made in the name of the provider entity as maker or comaker of the note.

(ii) Interest expense on related-party loans is limited to the lesser of:

(I) the cost to the provider entity, which is the cost to the related party; or

(II) the prevailing national average prime interest rate during the year in which the loan contract was finalized, as reported by the U. S. Department of Commerce, Bureau of Economic Analysis, in the Survey of current Business and the Business conditions Digest.

(D) Tax expense. This includes ad valorem, real and personal property taxes, motor vehicle registration fees, sales taxes, Texas corporate franchise taxes, and organization filing fees.

(E) Insurance expense. This includes facility fire and casualty, professional liability and malpractice, and transportation equipment liability insurance.

(6) Utilities expense. This includes electricity and natural gas, water, waste water, garbage collection, and telephone.

(7) Materials and supplies. These include office, activities, and educational supplies.

(8) Training expenses. These are limited to direct costs for travel, lodging, food, registration fees for personnel who provide services directly to DAHS recipients. Training must be related directly to the care of recipients in a DAHS facility.

(9) Contract services provided by outside vendors. This includes laundry and linen service, janitorial service, plant operation and maintenance expenses, and professional services such as those of accountants and attorneys.

*§50.6906. Unallowable costs.*

**(a) Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §50.6907 of this title (relating to Reimbursement Methodology for Day Activity and Health Services: 1996 and Subsequent Cost Reports).**

**(b)** Unallowable costs are expenses incurred by a provider agency which are not directly or indirectly related to the provision of contracted services according to applicable laws, rules, and standards. A provider agency may expend funds on unallowable cost items, but those costs must not be included in the cost report and are not used in calculating a reimbursement [rate] recommendation. The following list is a general guide to the various unallowable costs frequently encountered in cost reports submitted by provider agencies and is not intended to be inclusive of all possible unallowable costs:

(1) advertising expenses other than those for employee recruitment, yellow page listings no larger than one column width and one inch length, and advertising to meet statutory or regulatory requirements;

(2) allowances for bad debts or other similar accounts;

(3) business expenses not related to the provision of services for which the department has contracted;

(4) contributions to political activities or contributions to charity;

(5) corporate headquarters expenses that are not directly involved in providing services or supplies used by the Day Activity and Health Services agency staff in normal operations related to day activity and health services;

(6) depreciation expenses other than those based on straight-line depreciation;

(7) discounts for administrative reasons; courtesy, cash, trade, and quantity discounts; rebates; or other discounts granted;

(8) dues and membership fees to organizations whose primary emphasis is not related to the services for which the department has contracted;

(9) entertainment expenses, except for entertainment which is reported as an employee benefit;

(10) expenses incurred for services not related to the provision of services for which the department has contracted;

(11) expenses which are not the legal obligation of the provider agency;

(12) expenses of donated items, including depreciation and amortization of the value of the donations;

(13) fees and travel expenses for corporation or association board of directors;

(14) partnership or corporation filing fees;

(15) fines and other penalties for violation of statutes or ordinances; penalties for late payment of taxes, utilities, mortgages, loans, and other similar penalties;

(16) franchise fees;

(17) fund-raising and promotion expenses; public relations expenses;

(18) expenses for life insurance premiums where the beneficiary is the provider organization unless life insurance is a requirement of a loan agreement and the loan is related to client care;

(19) interest expenses on loans for assets not related to the delivery of services for which the department has contracted; interest expense must be reduced or offset by interest income except interest income from funded depreciation accounts or qualified pension funds;

(20) personal compensation not related to the delivery of services for which the department has contracted;

(21) personal expenses not related to the delivery of services for which the department has contracted;

(22) physician's fees for completion of physician orders;

(23) expenses for the purchase of services, facilities, or supplies from related organizations or parties if the expenses exceed the lower of the cost to the related party or organization or the price of comparable services, facilities, or supplies purchased in an arm's length transaction;

(24) rental or lease expense on any item not related to the delivery of services for which the department has contracted;

(25) tax expense for federal, state, or local income tax; any tax levied on assets not related to the delivery of services for which the department has contracted;

(26) values assigned to the services of unpaid workers or volunteers;

(27) building depreciation expenses based on less than a 30-year life;

(28) contributions to self-insurance funds that do not represent payment on current liabilities;

(29) expenses that cannot be adequately documented;

(30) forms of compensation that are not clearly enumerated to dollar amount or that represent profit distributions;

(31) insurance premiums pertaining to items of unallowable cost; [and]

(32) transportation expenses for vehicles which are not generally suited to functions related to the provision of services for which the department has contracted. Mileage expense may be included at a cost per mile not to exceed the current reimbursement [rate] set by the legislature for state employee travel; **and** [.]

**(33) costs for which the provider received federal funds, other than United States Department of Agriculture (USDA) funds, which should have been offset.**

*§50.6907. Reimbursement Methodology for Day Activity and Health Services: 1996 and Subsequent Cost Reports.*

(a) Day Activity and Health Care Services. Day activity and health care facilities provide noninstitutional care to clients residing in the community through rehabilitative nursing and social services. The Texas Department of Human Services (DHS) reimburses Day Activity and Health Services (DAHS) provider agencies for the services they provide to clients.

(b) General requirements. For the completion and submittal of cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years, providers must apply the information in this section. DHS applies the general principles of cost determination as specified in §20.101 of this title (relating to Introduction).

(c) Cost-reporting guidelines. Providers must follow the cost-reporting guidelines as specified in §20.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(d) Exclusion of cost reports.

(1) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursement. DHS excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services and are consistent with federal and state regulations.

(2) Individual cost reports may not be included in the database used for reimbursement determination if:

(A) there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported;

(B) there is reasonable doubt that a provider entity reflected economic and efficient operation due to low utilization or operation for less than a full fiscal year; or

(C) an auditor determines that reported costs are not verifiable.

(3) When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from reimbursement determination for the reasons stated in paragraph (2)(A) and (B) of this subsection.

(e) Review of cost reports. DHS staff perform either desk reviews or field audits of all contracted providers. The frequency and nature of the field audits are determined by DHS to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §20.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and providers will be notified of the results of a desk review or a field audit in accordance with §20.107 of this title (relating to Notification of Exclusions and Adjustments). Providers may request an informal and, if necessary, an administrative hearing to dispute an action taken by DHS under §20.110 of this title (relating to Informal Reviews and Formal Appeals) .

(f) Reimbursement determination. DHS determines reimbursement in the following manner. If cost reports covering less than a full fiscal year of operation are used in reimbursement determination, costs and other data are not annualized for purposes of determining per-unit costs and reimbursement.

(1) All contracted providers must submit a cost report unless the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer. The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost-report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity. Requests to be excused from submitting a cost report must be received by the DHS's Rate Analysis Department before the due date of the cost report.

(2) DHS staff allocate payroll taxes and employee benefits to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense. The employee benefits for administrative staff are allocated directly to the corresponding salaries for those positions. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or Social Security, Workers' Compensation Insurance (WCI), Federal Unemployment Tax Act (FUTA), and the Texas Unemployment Compensation Act (TUCA).

(3) DHS staff project all allowable expenses for the period from each provider's reporting period to the next ensuing reimbursement period. DHS staff determine reasonable and appropriate economic adjusters as described in §20.108 of this title (relating to Determination of Inflation Indices) to calculate the projected expenses. Depreciation and mortgage interest expenses are not projected. DHS staff also adjust reimbursement if new legislation, regulations, or economic factors affect costs as specified in §20.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).

(4) DHS staff combine allowable reported costs into the following six cost areas:

(A) Salaries and benefits cost area includes the salaries, wages, payroll taxes, and benefits of Day Activity and Health Services personnel, excluding dieticians, food servers, and administrative staff.

(B) Transportation cost area includes the rental or lease of transportation equipment and operating costs. The driver's salary is not included in this cost area.

(C) Food and food service cost area includes the cost of meals, related supplies, dieticians, and food servers.

(D) Building, equipment, and capital cost area includes all building operation expenses.

(E) Utility cost area includes all water, electric, gas, and telephone expenses.

(F) Direct programmatic expenses cost area includes the costs of medical and activity supplies, and administration, including administrative staff.

(5) Allowable costs are totaled by cost area and then divided by the total units of service for the reporting period to determine the cost per unit of service. DHS staff rank from low to high all provider agencies' projected costs per unit of service in each cost area. The median projected unit of service cost from each cost area is then determined. The median unit of service cost is multiplied by 1.044 and the resulting cost area amounts are then totaled to become the recommended reimbursement.

(6) The reimbursement determination authority is specified in §20.101 of this title (relating to Introduction).

(g) Allowable and unallowable costs. Providers must follow the guidelines specified in §20.102 of this title (relating to General Principles of Allowable and Unallowable Costs) in determining whether a cost is allowable or unallowable. Providers must follow the guidelines for allowable and unallowable costs specified in §20.103 of this title (relating to Specifications for Allowable and Unallowable Costs).

(h) DAHS-specific allowable costs. Allowable costs specific to the DAHS program are certain medical equipment and supplies. These are allowable costs if they are related to the services for which DHS has contracted. This may include, but is not limited to, supplies and equipment considered necessary to perform client assessments, medication administration, and nursing treatment.

(i) DAHS-specific unallowable costs. Unallowable costs specific to the DAHS program are:

(1) physician's fees for completion of physician orders;

(2) costs for food and food services which should have been offset by the United States Department of Agriculture (USDA) revenue as specified in §20.103(b)(15)(B) of this title (relating to Specification for Allowable and Unallowable Costs); and

(3) costs for which the provider received federal funds which should have been offset as specified in §20.103(b)(15)(B) of this title (relating to Specification for Allowable and Unallowable Costs).

(j) Reporting revenue. Revenue must be reported on the cost report according to §20.104 of this title (relating to Revenue).

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 24, 1995.

TRD-9509245 Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

Earliest possible date of adoption: September 1, 1995

For further information, please call: (512) 450-3765

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## • 40 TAC §50.6903

*(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Department of Human Services or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)*

The repeal is proposed under the Human Resources Code, Title 2, Chapters 22 and 32, which authorizes the department to administer public and medical assistance programs; and under Texas Civil Statutes, Article 4413(502), §16, which provide the Health and Human Services Commission with the authority to administer federal medical assistance funds.

The repeal implements the Human Resources Code, §§22.001-22.024 and §§32.001-32.042.

*§50.6903. Reimbursement Rate Determination.*

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 24, 1995.

TRD-9509244 Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

Earliest possible date of adoption: September 1, 1995

For further information, please call: (512) 450-3765

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# Chapter 52. Emergency Response Services

## Claims

## • 40 TAC §52.502, §52.504

The Texas Department of Human Services (DHS) proposes an amendment to §52.502 and new §52.504, concerning reimbursement methodology, in its Emergency Response Services chapter. The purpose of the amendment and new section is to clarify current reimbursement methodology practice and incorporate cost report procedural changes and to establish cost determination rules that are consistent across programs, provide explicit guidelines for auditors, provide specific instructions concerning cost reporting, and provide guidelines in areas such as documentation and allocation methods.

These sections were proposed in the December 30, 1994, issue of the *Texas Register* and withdrawn on June 27, 1995. The current proposal includes the original proposal as revised in response to public comments received during that publication process.

Also in this issue of the *Texas Register*, DHS is proposing new Chapter 20 and related policies in Chapters 19, 24, 46, 47, 48, and 50 of this title.

Burton F. Raiford, commissioner, has determined that for the first five-year period the sections are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the sections.

Mr. Raiford also has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be a better understanding of the reimbursement methodology due to inclusion of additional detail and a single set of guidelines to facilitate financial accountability relating to service delivery. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the proposed sections.

A public hearing will be held at 3:00 p.m. on August 16, 1995, in the Texas Department of Mental Health and Mental Retardation Central Office auditorium at 909 West 45th Street in Austin.

Questions about the content of this proposal may be directed to Carolyn Pratt at (512) 450-4057 in DHS's Rate Analysis Department. Written comments on the proposal may be submitted to Nancy Murphy, Media and Policy Services-177, Texas Department of Human Services E-205, P.O. Box 149030, Austin, Texas 78714-9030, within 30 days of publication in the *Texas Register*.

The amendment and new section are proposed under the Human Resources Code, Title 2, Chapter 22, which authorizes the department to administer public assistance programs.

The amendment and new section implement the Human Resources Code, §§22.001-22.024.

*§52.502. Reimbursement Methodology for Emergency Response Services.*

**(a) General requirements. Cost reports pertaining to providers' fiscal years ending in calendar year 1994 or 1995 will be governed by the information in this section. Cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years will be governed by the information in §52.504 of this title (relating to Reimbursement Methodology for Emergency Response Services: 1996 and Subsequent Cost Reports).**

(b)[(a)] Cost reporting.

(1) Content of cost report. Each provider agency must submit financial and statistical information at least annually in a cost report prescribed by the Texas Department of Human Services (DHS).

(2) Cost report due date. The provider agency must submit the cost report no later than 90 days after receiving the cost report forms. An extension of the due date may be granted for good cause (when conditions are outside the provider agency's control). The provider agency must submit a written request to extend the due date.

(3) Reporting period. The provider agency must prepare the cost report to reflect its activities during the previous fiscal year. At DHS's discretion, cost reports may be required for other periods.

(4) Failure to file an acceptable cost report. Failure to file a cost report according to all applicable rules and instructions may result in DHS withholding all provider agency payments until the provider agency submits an acceptable report.

(5) Accounting requirements. The provider agency must ensure that financial and statistical data submitted in cost reports are based upon the accrual method of accounting, except for governmental institutions operated on the cash method of accounting. The treatment given any financial or statistical item must reflect the application of the generally accepted accounting principles (GAAP) approved by the American Institute of Certified Public Accountants

(6) Financial audits. Desk audits and on-site audits are performed periodically on all provider agencies participating in the program. The frequency and nature of the audits are determined by DHS but are not less than that required by federal regulations relating to the administration of the program. Failure to allow DHS to perform an audit in sufficient detail to verify reported information may result in the provider agency payments being withheld.

(7) Recordkeeping requirements. Records must be maintained according to the requirements in **§69.205** [§69.202] of this title (relating to **Contractor's** [Contractors'] Records).

(8) Failure to maintain records. A provider agency that is not maintaining adequate records to support the financial and statistical information reported in cost reports has **30** [90] days to bring recordkeeping into compliance. Failure to correct deficiencies within **30** [90] days from the date the provider agency is notified of deficiency may result in the contract being cancelled.

(9) Amended cost report due dates. All contracted providers must submit cost reports to DHS in a manner prescribed by DHS. DHS accepts amended cost reports submitted on the request of the provider until 180 days after the due date of the cost report. Since this is a prospective reimbursement system without a provision for reconciliation, amended cost reports filed after this date have no effect on the **reimbursement** [rate] and are not accepted.

(10) Cost of out-of-state audits. Whenever possible, the records necessary to verify information submitted to DHS on Medicaid cost reports, including related-party transactions and other business activities engaged in by the provider, must be accessible to DHS audit staff in the state of Texas. When records are not available to DHS audit staff within the state, the provider must pay the costs for DHS staff to travel and review the records out-of-state. If a provider fails to reimburse DHS for these costs within 30 days of the request for payment, DHS may request a hold be placed on the vendor payments until the costs are paid in full.

[(b) Reimbursement rate ceiling determination.

[(1) The reimbursement rate ceiling is determined on a per-month basis. The ceiling applies to all provider agencies uniformly, regardless of geographic location or other factors.

[(2) The reimbursement rate ceiling is determined by the analysis of financial and statistical data submitted by provider agencies on cost reports and, as deemed appropriate, a market survey analysis of emergency response equipment suppliers.

[(3) The rate ceiling determination process recasts reported expense data in a consistent manner to determine per-month allowed costs. Reported expenses are combined into three cost areas-responder, program operations, and facility.

[(4) Allowable expenses are projected from the provider agency's reporting period to the next ensuing rate period. Economic inflators or adjusters determined reasonable and appropriate by DHS are used to calculate a prospective expense.

[(5) The Texas Board of Human Services is responsible for approving the reimbursement rate ceiling.]

**(c) Reimbursement ceiling determination.**

**(1) Reimbursement ceiling. The reimbursement ceiling is determined for a per-month unit of service. The ceiling applies to all provider agencies uniformly, regardless of geographic location or other factors.**

**(2) Excused from submission of cost reports. All contracted providers must submit a cost report unless the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer. The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity. Requests to be excused from submitting a cost report must be received by DHS's Rate Analysis Department before the due date of the cost report.**

**(3) Exclusion of cost reports.**

**(A) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursement. DHS excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the data base reflects costs and other information which are necessary for the provision of services and are consistent with federal and state regulations.**

**(B) Individual cost reports may not be included in the data base used for reimbursement determination if:**

***(i)*** **there is a reasonable doubt as to the accuracy or allowability of a significant part of the information reported;**

***(ii)*** **there is reasonable doubt that a provider entity reflected economic and efficient operation due to low utilization or operation for less than a full fiscal year; or**

*(iii)* an auditor determines that reported costs are not verifiable.

(C) When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from reimbursement determination for the reasons stated in subparagraph (B)(i) and (ii) of this paragraph.

(4) Recommended reimbursement ceiling. DHS determines a recommended reimbursement ceiling in the following manner. The reimbursement ceiling is determined by the analysis of financial and statistical data submitted by provider agencies on cost reports and, as deemed appropriate, a market survey analysis of emergency response equipment suppliers. If cost reports covering less than a full fiscal year of operation are used in reimbursement determination, costs and other data are not annualized for purposes of determining per-unit costs and reimbursement.

(A) DHS allocates payroll taxes and employee benefits to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense. The employee benefits for administrative staff are allocated directly to the corresponding salaries for those positions. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or social security, Workers' Compensation Insurance (WCI), the Federal Unemployment Tax Act, and Texas Unemployment Compensation Act.

(B) Allowable expenses are projected from the provider agency's reporting period to the next ensuing reimbursement period. Depreciation and mortgage interest expenses are not projected. DHS may also adjust reimbursement if new legislation, regulations, or economic factors affect costs.

(C) Allowable reported expenses are combined into three cost areas: responder, program operations, and facility. To determine the projected cost per unit of service a contracted provider's projected expenses in each cost area are divided by its total units of service for the reporting period.

(D) The contracted providers' projected costs per unit of service are ranked from low to high in each cost area, with corresponding units of service.

(E) The 80th percentile cost, weighted by units of service, is determined for each cost area. The recommended reimbursement ceiling is the sum of the 80th percentile costs of the three cost areas.

(F) The Texas Board of Human Services (board) determines a prospective uniform reimbursement ceiling at least annually, unless the board decides otherwise.

[(c) Contract-specific unit rate. The actual rates for each contract are negotiated between DHS staff and the provider agency. The contract-specific unit rate DHS pays the provider agency is the full cost for emergency response services. The provider agency must not bill the client for any additional charges.]

(d) Contract-specific unit reimbursement. The actual reimbursement for each contract is negotiated between DHS staff and the provider agency. The contract-specific reimbursement DHS pays the provider agency is the full cost for emergency response services. The provider agency must not bill the client for any additional charges. In no instance may the negotiated unit reimbursement exceed the per-month reimbursement ceiling.

(e) [(d)] Factors affecting allowable costs. To be allowable under this program, the provider agency must ensure that costs are:

(1) necessary and reasonable for the proper and efficient administration of a program to deliver services for which the department has contracted;

(2) authorized or not prohibited under state or local laws or regulations;

(3) consistent with any limitations or exclusions described in this section, federal or state laws, or other governing limitations on types or amounts of cost items;

(4) consistent with policies, regulations, and procedures that apply uniformly to both the Emergency Response Services Program and other activities of the organization of which the provider agency is part;

(5) subject to consistent treatment using generally accepted accounting principles appropriate to the circumstances;

(6) not allocable to or included as a cost of any other program in either the current or a prior period; and

(7) the net of all applicable credits.

(f)[(e)] Definition of reasonableness. A cost is reasonable if, in its nature and amount, it does not exceed the cost that would be incurred by an ordinarily prudent person conducting competitive business. In determining the reasonableness of a given cost, the department considers the following:

(1) whether the cost is of a type generally recognized as ordinary and necessary for the operation of the business or its performance under the contract;

(2) the restraints or requirements imposed by generally accepted sound business practices, arm's length bargaining, federal and state laws and regulations, and contract terms and specifications; and

(3) the action that a prudent person would take in the circumstances, considering his responsibilities to the public, the government, his employees, clients, shareholders, or members, and the fulfillment of the purpose for which the business was organized.

(g)[(f)] Unallowable costs. Unallowable costs are expenses the provider agencies incurred that are not directly or indirectly related to providing contracted services according to applicable laws, rules, and standards. The following list of expenses is not inclusive but rather a guide to the various unallowable costs frequently seen in cost reports:

(1) advertising expenses, except advertising for employee recruitment and advertising to meet statutory or regulatory requirements;

(2) allowances for bad debts or other uncommon accounts;

(3) business expenses from business operations not related to providing services for which DHS has contracted;

(4) contributions to political activities or to charity;

(5) discounts for administrative reasons; courtesy, cash, trade, and quantity discounts; rebates; or other discounts;

(6) dues and membership fees;

(7) entertainment expenses, except for entertainment that is reported as an employee benefit;

(8) expenses incurred for services not related to providing services contracted for by DHS;

(9) expenses for purchasing goods and services from revenues received from restricted or unrestricted gifts, donations, endowments, and trusts;

(10) expenses that are not the provider agency's legal obligation;

(11) expenses of donated items, including depreciation and amortization of the value of the donations;

(12) fees for corporation or association board of directors, partnership, or corporation filing fees;

(13) fines and other penalties for violating statutes or ordinances and penalties for late payment of taxes, utilities, mortgages, and other similar penalties;

(14) fund-raising, promotion expenses, and public relations expenses;

(15) insurance expenses for life insurance premiums if the beneficiary is the provider agency, and for insurance on assets not related to delivering services for which DHS has contracted;

(16) interest expense on loans for assets not related to delivering of services for which DHS has contracted (interest expenses must be reduced or offset by interest income except interest income from funded depreciation accounts or qualified pension funds);

(17) personal compensation to persons not providing services contributory to delivering services for which DHS has contracted;

(18) personal expenses not related to delivering services for which DHS has contracted;

(19) expenses for purchasing services, facilities, or supplies from related organizations or parties that exceed the lower of the cost to the related party or organization or the price of comparable services, facilities, or supplies purchased in an arm's length transaction;

(20) rental or lease expense on any item not related to delivering services for which DHS has contracted;

(21) tax expenses for federal, state, or local income tax, and any tax levied on assets not related to delivering services for which DHS has contracted;

(22) transportation expenses for vehicles not generally suited to functions related to delivering services for which DHS has contracted. Mileage can be included at a cost per mile not to exceed the current reimbursement rate set by the legislature for state employees travel. Mileage is allowable if documentation is adequate and if the expense incurred was related to delivering services for which DHS has contracted; and

(23) the expense of base station equipment at the response center.

*§52.504. Reimbursement Methodology for Emergency Response Services (ERS): 1996 and Subsequent Cost Reports.*

(a) General requirements. For the completion and submittal of cost reports pertaining to providers' fiscal years ending in calendar year 1996 and subsequent years, providers must apply the information in this section. The Texas Department of Human Services (DHS) applies the general principles of cost determination as specified in §20.101 of this title (relating to Introduction).

(b) General reporting guidelines. Providers must follow the cost-reporting guidelines as specified in §20.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(c) Reimbursement ceiling determination.

(1) Reimbursement ceiling. The reimbursement ceiling is determined for a per-month unit of service. The ceiling applies to all provider agencies uniformly, regardless of geographic location or other factors.

(2) Excused from submission of cost reports. All contracted providers must submit a cost report unless the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer. The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity. Requests to be excused from submitting a cost report must be received by DHS's Rate Analysis Department before the due date of the cost report.

(3) Exclusion of cost reports.

(A) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursement. DHS excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the data base reflects costs and other information which are necessary for the provision of services and are consistent with federal and state regulations.

(B) Individual cost reports may not be included in the data base used for reimbursement determination if:

(i) there is a reasonable doubt as to the accuracy or allowability of a significant part of the information reported;

(ii) there is reasonable doubt that a provider entity reflected economic and efficient operation due to low utilization or operation for less than a full fiscal year; or

(iii) an auditor determines that reported costs are not verifiable.

(C) When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from reimbursement determination for the reasons stated in subparagraph (B)(i) and (ii) of this paragraph.

(4) Recommended reimbursement ceiling. DHS determines a recommended reimbursement ceiling in the following manner. The reimbursement ceiling is determined by the analysis of financial and statistical data submitted by provider agencies on cost reports and, as deemed appropriate, a market survey analysis of emergency response equipment suppliers. If cost reports covering less than a full fiscal year of operation are used in reimbursement determination, costs, and other data are not annualized for purposes of determining per-unit costs and reimbursement.

(A) DHS allocates payroll taxes and employee benefits to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense. The employee benefits for administrative staff are allocated directly to the corresponding salaries for those positions. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or social security, Workers' Compensation Insurance (WCI), the Federal Unemployment Tax Act, and Texas Unemployment Compensation Act.

(B) Allowable expenses are projected from the provider agency's reporting period to the next ensuing reimbursement period. DHS determines reasonable and appropriate economic inflators or adjusters as described in §20.108 of this title (relating to Determination of Inflation Indices) to calculate a prospective expense. Depreciation and mortgage interest expenses are not projected. DHS also adjusts reimbursement if new legislation, regulations, or economic factors affect costs as specified in §20.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).

(C) Allowable reported expenses are combined into three cost areas: responder, program operations, and facility. To determine the projected cost per unit of service a contracted provider's projected ex-

penses in each cost area are divided by its total units of service for the reporting period.

(D) The contracted providers' projected costs per unit of service are ranked from low to high in each cost area, with corresponding units of service.

(E) The 80th percentile cost, weighted by units of service, is determined for each cost area. The recommended reimbursement ceiling is the sum of the 80th percentile costs of the three cost areas.

(F) The reimbursement determination authority for this reimbursement ceiling is specified in §20.101 of this title (relating to Introduction).

(d) Contract-specific unit reimbursement. The actual reimbursement for each contract is negotiated between DHS staff and the provider agency. The contract-specific reimbursement DHS pays the provider agency is the full cost for emergency response services. The provider agency must not bill the client for any additional charges. In no instance may the negotiated unit reimbursement exceed the per-month reimbursement ceiling.

(e) Reviews and field audits of cost reports. DHS staff perform either desk reviews or field audits on all contracted providers. The frequency and nature of the field audits are determined by DHS staff to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §20.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and providers will be notified of the results of a desk review or a field audit in accordance with §20.107 of this title (relating to Notification of Exclusions and Adjustments). Providers may request an informal and, if necessary, an administrative hearing to dispute an action taken by DHS under §20.110 of this title (relating to Informal Reviews and Formal Appeals).

(f) Factors affecting allowable costs. In determining whether a cost is allowable or unallowable, providers must follow the guidelines specified in §20.102 of this title (relating to General Principles of Allowable and Unallowable Costs). Providers must follow the guidelines for allowable and unallowable costs as specified in §20.103 of this title (relating to Specifications for Allowable and Unallowable Costs) and follow the guidelines for unallowable costs specific to the ERS program as specified in subsection (g) of this section.

(g) Unallowable cost. The unallowable cost specific to the ERS program is the expense of base station equipment at the response center.

(h) Reporting revenue. Revenue must be reported on the cost report according to §20.104 of this title (relating to Revenue).

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on July 24, 1995.

TRD-9509239

Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

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For further information, please call: (512) 450-3765