



**Presentation to the House Appropriations  
Committee on Article II:  
Overview of Medicaid Cost Reporting for Long  
Term Services and Supports Programs**

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# Overview of LTSS Rate Setting Medicaid Rate Setting Methodologies

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- **Methodologies vary based on type of service, whether service has a Medicare equivalent, federal law, and available data.**
- **Acute Care (physicians, CORF/ORF, HHA, DME, medical supplies, SHARS, MAC)**
  - Resource-based Fees: equal to Medicare Relative Value Unit (RVU) for the service multiplied by applicable Medicaid conversion factor.
  - Access-based Fees:
    - Healthcare Common Procedure Coding System Fee Analyzer
    - Average or percentage of Wholesale Price (AWP)
    - Medispan – online database of AWP and Average Sales Price for drugs and biologicals
    - Mean or median of the Medicaid fees for 10 most populous states plus four states bordering Texas
    - Current Texas Medicaid fee for similar service
    - Manufacturer Suggested Retail Price
  - Cost reports and time study-based fees (SHARS and MAC)
- \* Note: A list of Acronyms can be found in the Appendix

# Overview of LTSS Rate Setting Medicaid Rate Setting Methodologies (cont.)

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- **Hospitals (inpatient and outpatient hospital, ASC/HASC, FQHC/RHC, IMD, renal dialysis facilities)**
  - Cost report-based (inpatient and outpatient hospital)
  - Tied to Medicare (ASC/HASC, IMD, Renal Dialysis)
  - Methodology dictated by federal law (FQHC/RHC)
- **Long Term Services and Supports (NFs, hospice, ICF/IID, HCS/TxHmL, CLASS, CFC, MDCP, DBMD, PHC/CAS/FC, DAHS, RC, MEI, SSLC, Child Foster Care including Foster Care Redesign, YES, HCS-AMH, CRS – PABI)**
  - Cost report-based (NF, ICF/IID, HCS/TxHmL, CLASS, PHC/CAS/FC, DAHS, RC, MEI, Child Foster Care)
  - Cost-based (Veterans NFs, SSLCs, Pediatric NFs)
  - Pro forma modeling (MDCP, DBMD, YES, HCS-AMH, CFC, CRS-PABI, Foster Care Redesign)
  - Dictated by federal law (Hospice)

\* Note: A list of Acronyms can be found in the Appendix

# Overview of LTSS Rate Setting: Cost Reporting

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- LTSS Medicaid cost reports are designed and maintained by HHSC.
- Administered through web-based application
- Cost report preparers are required to take web-based training every other year.
- Cost reports are collected from both fee-for-service (FFS) and managed care providers. Currently, HHSC collects cost reports from about 5,800 providers annually.
- Allowable and unallowable costs are regulated by Texas Administrative Code rules that are similar to Medicare and Office of Management and Budget (OMB) rules.
- 100% of cost reports are reviewed by HHSC Rate Analysis cost report auditors.
- Costs are trended from the reporting period to the rate period.
- Rates are typically based on average costs (for direct care) or median costs (for non-direct care) costs.

# Federal Requirements for Cost Reporting

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- The Medicaid agency must provide for the filing of **uniform cost reports by each participating provider** (applies to ICF/IID and NF). (42 CFR 477.253(f) Uniform cost reporting)
- The Medicaid agency must provide for **periodic audits** of the financial and statistical records of participating providers. (42 CFR 447.253(g) Audit Requirements)
- States are required to ensure that Medicaid payments are consistent with **efficiency, economy, and quality of care**. (Section 1902 of the Social Security Act [42 U.S.C. 1396a] )
- Medicaid payments **must not exceed an upper payment limit** equal to a reasonable estimate of the amount that would be paid for the services if furnished under Medicare payment principles. (42 CFR 447.272(b) Application of upper payment limits)

# Texas' Rules and Requirements for Cost Reporting

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- Texas' Medicaid Cost Determination Process rules are based on Federal guidance and statutes.
- Texas' Medicaid Cost Determination Process rules are incorporated in the Texas State plan by reference.
  - Any changes to these rules would have to be approved by the Centers for Medicare & Medicaid Services (CMS)
  - “Whenever a change is made to the definitions of allowable and unallowable costs...relating to Cost Determination Process which is anticipated to cause a change in the rate payable to a provider, a State plan amendment will be submitted.”

# LTSS Cost Reporting

## Number of Texas Medicaid Cost Reports by Program

Program	Count	%
24-Hour Residential Child Care and Supervised Independent Living Program (24RCC/SIL)	285	4.9%
Primary Home Care (PHC) & Community Living Assistance and Support Services (CLASS)	1,800	30.8%
Day Activity & Health Services (DAHS)	520	8.9%
Deaf Blind with Multiple Disabilities Waiver (DBMD)	15	0.3%
Mental Health Case Management & Rehab Services / Early Childhood Intervention / Service Coordination for ICF/IID (MEI)	70	1.2%
Nursing Facility (NF)	1,150	19.7%
Residential Care (RC)	350	6.0%
School Health & Related Services (SHARS)	780	13.4%
Home and Community-Based Services (HCS)	700	12.0%
Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID)	150	2.6%
ICF/IID - State Supported Living Centers (SSLC)	13	0.2%
ICF/IID - Bond Homes (BH)	4	0.1%
<b>Total</b>	<b>5,837</b>	<b>100.0%</b>

# LTSS Cost Reporting Typical Texas Medicaid Cost Report Cycle

Project	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Cost report submission request - Jan 15th																						
Provider completion period (90 days) - Due Apr 15th																						
Submission extensions & Special requests																						
Training conducted via webinar sessions																						
Audits performed for data verification																						
Provider adjustment & Recoupment notifications																						
Data Analysis - Rate Setting (odd-year cost reports)																						
Data Analysis - Consolidated Budget (even-year cost reports)																						
Rate determination and proposal																						
Rate Hearing																						
State Plan Amendments																						
Rate Implementation																						

- General principles for allowable and unallowable costs. Allowable and unallowable costs are defined to identify expenses that are **reasonable and necessary** to provide contracted client care and are consistent with federal and state laws and regulations.
  - 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 services. In determining reasonableness of a given cost, the following are considered:
    - The restraints or requirements imposed by arm's length bargaining, i.e., transactions with non-owners or other unrelated parties, federal and state laws and regulations, and contract terms and specifications; and
    - The actions 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.
  - Necessary refers to the relationship of the cost incurred by a provider to the provision of contracted client care.
- Detailed listing of Allowable and Unallowable Costs. See APPENDIX.

- Some providers object to limitations on reporting of related-party expenses.
- Some providers of residential waiver services (e.g., Home and Community-based Services [HCS] Supervised Living/Residential Support Services) object to disallowance of room and board costs. However, Section 1915(c) of the Social Security Act [42 U.S.C. 1396n] requires the exclusion of room and board costs from rates for waiver services provided in residential settings.
- Some providers would like to use accelerated depreciation and/or shorter useful lives for estimating building costs. HHSC requires use of straight-line depreciation and a 30-year life. Other depreciable lives are based on “Estimated Useful Lives of Depreciable Hospital Assets” published by the American Hospital Association.

- Related-party transactions. Costs applicable to services, equipment, facilities, leases, or 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, leases, or supplies that could be purchases or leased elsewhere. The purpose of this principle is two-fold:
  - To avoid the payment of a profit factor to the contracted provider through the related organization; and
  - To avoid payment of artificially inflated costs which may be generated from less than arm's-length bargaining.

- Texas Medicaid does not allow providers to report court-ordered awards 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.
- **Texas does not disallow any other costs that are not federally required to be disallowed.**

# LTSS Cost Reporting

## Top 10 Audit Disallowances – HCS 2014

**Cost Report Year: 2014**

**Program: HCS**

**Top 10 Audit Disallowances**

Adjustment Code	Original Value	Adjusted Value	Change
Related party salary limits -- 355.105(i) -- 602	8,783,046	5,162,378	(3,620,668)
Lack of adequate documentation -- 105(b)(2) -- 27	4,062,031	1,298,643	(2,763,388)
Compensation of employees -- 103(b)(1) -- 10	11,883,756	9,832,998	(2,050,758)
Business expense not directly related to contracted svcs -- 103(b)(17)(H) -- 7	4,865,739	3,400,373	(1,465,366)
Compensation of outside consultants and vendors -- 103(b)(2)(C) -- 11	8,428,401	7,019,510	(1,408,891)
Cost allocation -- 102(j) -- 13	5,586,047	4,560,757	(1,025,290)
Compensation of owners and related parties -- 103(b)(2) -- 12	2,694,593	1,677,510	(1,017,083)
Reasonable and necessary -- 102(f) -- 41	1,594,552	1,231,666	(362,886)
Tax expense and credits - payroll taxes -- 103(b)(9)(B) -- 51	10,264,820	10,030,596	(234,224)
Utilities -- 103(b)(5) -- 54	241,933	119,307	(122,626)
<b>Total for Top 10 Disallowances and Added Costs</b>			<b>(14,071,180)</b>

<b>TOTAL Net Disallowance</b>	90,610,043	77,422,402	<b>(13,187,641)</b>
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Total Expenses Initially Reported	\$874,397,479
Less Disallowed	(13,187,641)
Net Allowable Expenses	\$861,209,838
Disallowed as % of Total	-1.51%

# LTSS Cost Reporting

## Top 10 Audit Disallowances – ICF 2014

**Cost Report Year: 2014**

**Program: ICF**

### Top 10 Audit Disallowances

Adjustment Code	Original Value	Adjusted Value	Change
Related party salary limits -- 355.105(i) -- 602	3,091,500	1,224,848	(1,866,652)
Business expense not directly related to contracted svcs -- 103(b)(17)(H) -- 7	1,923,934	892,607	(1,031,327)
Tax expense and credits - payroll taxes -- 103(b)(9)(B) -- 51	4,139,666	3,926,970	(212,696)
Tax expense and credits - business and property -- 103(b)(9) -- 50	148,235	1,482	(146,753)
Reclassify -- 101(c)(2)(A) -- 42	6,040,956	5,957,808	(83,148)
Compensation of employees -- 103(b)(1) -- 10	1,486,668	1,405,654	(81,014)
Fringe benefits -- 103(b)(1)(A)(iii) -- 21	137,624	96,712	(40,912)
Lack of adequate documentation -- 105(b)(2) -- 27	150,852	118,315	(32,537)
Compensation of outside consultants and vendors -- 103(b)(2)(C) -- 11	128,009	100,127	(27,882)
Reasonable and necessary -- 102(f) -- 41	237,673	211,869	(25,804)
<b>Total for Top 10 Disallowances</b>			<b>(3,695,478)</b>

<b>TOTAL Net Disallowance</b>	<b>(3,408,143)</b>
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Total Expenses Initially Reported	\$290,491,436
Less Disallowed	(3,408,143)
Net Allowable Expenses	\$287,083,293
Disallowed as % of Total	-1.17%

# LTSS Cost Reporting

## Top 10 Audit Disallowances – CPC 2014

**Cost Report Year: 2014**

**Program: CPC**

### Top 10 Audit Disallowances

Adjustment Code	Original Value	Adjusted Value	Change
Compensation of employees -- 103(b)(1) -- 10	319,925,465	298,747,768	(21,177,697)
Cost allocation -- 102(j) -- 13	33,703,314	19,519,235	(14,184,079)
Related party salary limits - CPC -- 355.105(i)(1) -- 602	31,294,977	17,754,466	(13,540,511)
Reporting period -- 105(b) -- 45	17,754,466	6,294,904	(11,459,562)
Business expense not directly related to contracted svcs -- 103(b)(17)(H) -- 7	18,436,040	8,518,799	(9,917,241)
Lack of adequate documentation -- 105(b)(2) -- 27	3,628,205	335,914	(3,292,291)
Reasonable and necessary -- 102(f) -- 41	9,226,929	6,455,967	(2,770,962)
Reclassify -- 101(c)(2)(A) -- 42	232,554,394	231,241,823	(1,312,571)
Tax expense and credits - payroll taxes -- 103(b)(9)(B) -- 51	59,498,258	59,142,086	(356,172)
Central office costs -- 103(b)(4) -- 8	1,177,831	854,443	(323,388)
<b>Total for Top 10 Disallowances</b>			<b>(78,334,474)</b>

<b>TOTAL Net Disallowance</b>	<b>(72,474,697)</b>
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Total Expenses Initially Reported	\$2,134,368,306
Less Disallowed	(72,474,697)
Net Allowable Expenses	\$2,061,893,609
Disallowed as % of Total	-3.40%

- The 2004-05 General Appropriations Act (Article II, HHSC, Rider 45, H.B. 1, 78<sup>th</sup> Legislature, Regular Session, 2003) required HHSC to review and revise its intellectual and developmental disorder (IID) provider cost reporting process and to reduce any associated administrative costs. In addition, HHSC was charged with making these changes while maintaining both fair and accurate financial information which is necessary to the proper planning and funding of IID services in the State of Texas.
  - Multiple cost report items were consolidated or deleted.
  - HHSC developed web-based training modules so providers would no longer have to travel to cost report training sessions and streamlined content.
- H.B. 2540, 80<sup>th</sup> Legislature, Regular Session, 2007 required HHSC to develop and implement a pilot project to simplify, streamline, and reduce costs associated with Medicaid cost reporting and auditing for private intermediate care facilities for persons with mental retardation (ICFs/MR) and home and community-based services (HCS) providers and to establish a work group that reports to the commissioner and is responsible for developing and proposing cost report forms and processes, audit processes, and rules necessary to implement the pilot, a plan for monitoring the pilot and recommendations for improving and expanding the pilot to other programs; monitoring wage levels of direct-care staff to assess the value and need for minimum spending levels; and submitting quarterly reports regarding the status of the pilot.
  - Pilot cost reports were developed by the workgroup and modified based on pilot participant, HHSC OIG and HHSC RAD input. These pilot cost reports form the basis of the current ICF and HCS cost reports.
  - New web-based cost reports were implemented beginning with providers' 2010 cost reports.

# APPENDIX

# Past Legislative Actions

## 2004-05 Rider 45 Review of IID Cost Reporting

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- The 2004-05 General Appropriations Act (Article II, HHSC, Rider 45, H.B. 1, 78<sup>th</sup> Legislature, Regular Session, 2003) required HHSC to review and revise its intellectual and developmental disorder (IID) provider cost reporting process and to reduce any associated administrative costs. In addition, HHSC was charged with making these changes while maintaining both fair and accurate financial information which is necessary to the proper planning and funding of IID services in the State of Texas.
- HHSC contracted with Affiliated Computer Systems (ACS) and Public Consulting Group (PCG) to conduct an independent review of current IID cost reporting forms to obtain recommendations for improving and simplifying cost reporting forms and instructions used for IID service providers through an independent examination of current procedures and collection instructions.
- “Report on Current Mental Retardation (sic) Cost Reporting Forms” was submitted ACS/PCG to HHSC on February 6, 2006.

- Key Findings

- Issue: Providers wanted to submit audited financial statements in place of cost reports.
- Recommendation: "ACS/PCG does not feel that the use of financial statements in place of the current cost reporting forms would adequately capture the level of information that is necessary for rate determination and regulatory purposes. RAD oversees a variety of programs and services, as a result, it is critical that providers complete comparable reports of the discrete expenditures incurred in providing services to clients. Audited financial statements may include costs which are not allowable for Medicaid reimbursement; therefore, it would be inappropriate to use audited financial statements for cost reporting purposes. In addition, audited financial statements do not address many of the challenges associated with providers that operate multiple programs (funded by HHSC or other private sources) and services and therefore would inhibit HHSC's rate determination procedures. Audited financial statements would not provide the level of detail to allow HHSC to fulfill their current procedures, those required by TAC rule, federal regulation, and individual requests by the legislature."
- HHSC Action: None

- Key Findings (cont.)
  - Issue: HHSC currently requires a paper-based submission process for both the ICF/MR and HCS/TxHmL cost reporting forms.
  - Recommendation: HHSC planned to move to an electronic submission process by tailoring the Automated Cost Reporting & Evaluation System (ACRES) to facilitate the electronic submission of the 2005 MR cost reporting forms. ACS/PCG encourages HHSC to continue to move forward with this process as an electronic submission process will streamline efforts and minimize the administrative burden on HHSC and the provider community.
  - HHSC Action: ICF and HCS/TxHmL cost reports were moved to ACRES for the 2005 cost reporting period.
  - Issue: Inclusion of fiscal accountability worksheets in provider cost reports.
  - Recommendation: The primary purpose of the cost report is for a provider to document the true costs incurred while providing MR services to consumers in the State of Texas, not simply those related to direct care. ACS/PCG believes that the inclusion of the Fiscal Accountability Worksheets with the provider cost report, although optional, detracts from this primary purpose.
  - HHSC Action: HHSC removed Fiscal Accountability Worksheets from the cost reports.

- Key Findings (cont.)

- Issue: Providers claim that current time sheet documentation can be streamlined.
- Recommendation: While ACS/PCG understands the frustration of the providers regarding the amount of employee time consumed by the need to document their activities; it is recommended that HHSC maintain its current standards. It is necessary to adequately document time to ensure complete picture of provider operations. "General Auditing Standards require providers to appropriately document and report employee costs including the assurances that the work was performed. To satisfy these requirements, providers must document the time worked for the entire year."
- HHSC Action: None.
  
- Issue: Providers find training session confusing and time consuming.
- Recommendation: Training session should be streamlined to allow providers to only attend those portions that are applicable to them. Separate training sessions should continue to be held for HCS/TxHmL and ICF/MR in order to limit the exposure of providers to information that is not applicable to them and may create confusion.
- HHSC Action: HHSC developed web-based training modules so providers would no longer have to travel to cost report training sessions and streamlined content.

- **Key Findings (cont.)**
  - Issue: Providers expressed concerns over the submission dates of cost reports.
  - Recommendation: The State should set a uniform submission due date for all reports that is maintained each year so that providers will be able to plan their work schedules around this date. For the same reasons, it is advised that the annual training sessions be planned for the same series of weeks year after year as well.
  - HHSC Action: HHSC standardized cost report due dates and cost report training schedules.
  
  - Issue: Notarization of reports creates barriers for providers.
  - Recommendation: HHSC should remove the requirement on providers to have cost reports notarized.
  - HHSC Action: HHSC removed the requirement to have cost reports notarized.
  
  - Issue: Cost reports are too complex.
  - Recommendation: Consolidate or delete cost report items to reduce burden on providers and preparers.
  - HHSC Action: Multiple cost report items were consolidated or deleted.

- H.B. 2540, 80<sup>th</sup> Legislature, Regular Session, 2007 required HHSC to:
  - Develop and implement a pilot project to simplify, streamline, and reduce costs associated with Medicaid cost reporting and auditing for private intermediate care facilities for persons with mental retardation (ICFs/MR) and home and community-based services (HCS) providers.
  - Establish by rule and with the assistance of a workgroup, cost reporting and auditing processes and guidelines similar to standard business financial reporting processes and guidelines.
  - Establish a work group that reports to the commissioner and is responsible for developing and proposing cost report forms and processes, audit processes, and rules necessary to implement the pilot, a plan for monitoring the pilot and recommendations for improving and expanding the pilot to other programs; monitoring wage levels of direct-care staff to assess the value and need for minimum spending levels; and submitting quarterly reports regarding the status of the pilot.
  - Not later than September 1, 2012, submit a report to the Legislature that evaluates the operation of the pilot project and makes recommendations regarding the continuation or expansion of the pilot project.

- The H.B. 2540 workgroup met a total of seven times between January and November 2008. Members included:
  - HHSC RAD, HHSC OIG, and DADS staff
  - Chief of Staff from Representative Carl Isett's office.
  - Employees of private providers of ICF and/or HCS services.
  - Employees of public providers of ICF and/or HCS services
  - Representative of Private Providers Association of Texas (PPAT)
  - Private CPA.
- The workgroup developed pilot reports and a pilot methodology.
- The pilot was conducted between June and August 2008.
- The pilot reports were audited by HHSC OIG auditors between August and October 2008.
- The workgroup evaluated the pilot in October and November 2008.

- Issue: It was unclear whether Medicaid payment rates developed using data gathered through the processes described in the bill would entitle Texas to continue receiving Medicaid federal matching funds for the ICF and HCS programs.
- Approach: A letter was sent to CMS on September 28, 2007, requesting their guidance on this issue.
- CMS Response: In a November 6, 2007, letter, CMS indicated that “The regulation at 42 CFR 447.253(f) Uniform Cost Reporting states ‘The Medicaid agency must provide for the filing of uniform cost reports by each participating provider.’ Currently the Texas State Plan Section 4.19-D, ICF/MR, Page 1, V. requires a cost report to be submitted in accordance with pertinent cost report rules and cost report instructions. The State would need to assure that the same elements reported through the existing cost report were the same elements reported through the standard business financial reports.

- Changes made to IID cost reporting process as a result of the H.B. 2540 process:
  - Pilot cost reports were developed by the workgroup and modified based on pilot participant, HHSC OIG and HHSC RAD input. These pilot cost reports form the basis of the current ICF and HCS cost reports.
  - A contractor was procured to develop a web-based platform for the new cost reports.
  - New web-based cost reports were implemented beginning with providers' 2010 cost reports.
  - Fiscal accountability was suspended effective September 1, 2009.
  - Fiscal accountability was replaced by Attendant Compensation Rate Enhancement effective September 1, 2010.

## **TEXAS ADMINISTRATIVE CODE RULES; ALLOWABLE AND UNALLOWABLE COSTS**

### 355.102 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 that 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 §355.103(b)(19)(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 §355.103 of this title, revenue reporting guidelines in §355.104 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 Health and Human Services Commission (HHSC) 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, HHSC 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. It is the responsibility of the provider to ensure that each cost report preparer has completed the required state-sponsored cost report training. 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 complete cost report training for each program for which a cost report is submitted. Preparers must complete cost report training every other year for the odd-year cost report in order to receive a certificate to complete both that odd-year cost report and the following even-year cost report. If a new preparer wishes to complete an even-year cost report and has not completed the previous odd-year cost report training, to receive a certificate to complete the even-year cost report, he/she must complete an even-year cost report training. A copy of the most recent cost report training certificate for each preparer of the cost report must be submitted with each cost report, except for cost reports submitted through the State of Texas Automated Information and Reporting System (STAIRS). Contracted preparer's fees to complete state-sponsored cost report training are allowable.

(1) New preparers. Preparers, who have not previously completed the required state-sponsored cost report training and received a completion certificate, must complete the state-sponsored cost report training as follows:

(A) For School Health and Related Services (SHARS) providers, new preparers must complete state-sponsored online cost report training and receive a certificate of completion. Failure to complete the required training may result in an administrative contract violation as specified in §355.8443 of this title (relating to Reimbursement Methodology for School Health and Related Services (SHARS)). Applicable federal and state accessibility standards apply to online training.

(B) For all other programs, new preparers must complete the state-sponsored online cost report training designed for new preparers and receive a certificate of completion for each program for which a cost report is submitted. Applicable federal and state accessibility standards apply to online training.

(2) All other preparers. Preparers who are not new preparers as defined in paragraph (1) of this subsection must complete state-sponsored online cost report training and receive a certificate of completion for each program for which a cost report is submitted. Preparers that participate in online training may be assessed a convenience fee, which will be determined by HHSC. Convenience fees assessed for state-sponsored online cost report training are allowable costs. Applicable federal and state accessibility standards apply to online training.

(3) For nursing facilities, failure to file a completed cost report signed by preparers who have completed the required cost report training may result in vendor hold as specified in §355.403 of this title (relating to Vendor Hold).

(4) For SHARS providers, failure to complete the required cost report training may result in an administrative contract violation as specified in §355.8443 of this title.

(5) For all other programs, failure to file a completed cost report signed by preparers who have completed the required cost report training constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title (relating to Administrative Contract Violations).

(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, HHSC 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 §355.103 of this title;

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

(4) Indirect costs are those costs that benefit, or contribute to, the operation of providing contracted services, other business components, or the overall contracted entity. These costs could include, but are not limited to, administration salaries and nonlabor costs, building costs, insurance expense, and interest expense. Central office or home office administrative expenses are considered indirect costs. As specified in §355.8443 of this title, SHARS providers use an unrestricted indirect cost rate to determine indirect 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 §355.103 of this title or program-specific reimbursement methodology. Providers must not report as an allowable cost on a cost report a cost that has been determined to be unallowable. Such reporting may constitute fraud. (Refer to §355.106(a) of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports)).

(1) For nursing facilities, placement as an allowable cost on a cost report of a cost which has been determined to be unallowable may result in vendor hold as specified in §355.403 of this title.

(2) For Intermediate Care Facilities for Individuals with Intellectual Disabilities (formerly known as Intermediate Care Facilities for Persons with Mental Retardation), Home and Community-based Services, Service Coordination/Targeted Case Management, Rehabilitative Services, and Texas Home Living programs, placement as an allowable cost on a cost report a cost, which has been determined to be unallowable, constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(3) For SHARS providers, submission of a cost that has been determined to be unallowable may result in an administrative contract violation as specified in §355.8443 of this title.

(4) For all other programs, submission of a cost, which has been determined to be unallowable, constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(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.

(1) For nursing facilities, inaccuracy in providing, or failure to provide, required financial and statistical data may result in vendor hold as specified in §355.403 of this title.

(2) For Intermediate Care Facilities for Individuals with Intellectual Disabilities (formerly known as Intermediate Care Facilities for Persons with Mental Retardation), Home and Community-based Services, Service Coordination/Targeted Case Management, Rehabilitative Services, and Texas Home Living programs, inaccuracy in providing, or failure to provide, required financial and statistical data constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(3) For SHARS, inaccuracy in providing, or failure to provide, required financial and statistical data may result in an administrative contract violation as specified in §355.8443 of this title.

(4) For all other programs, inaccuracy in providing, or failure to provide, required financial and statistical data constitutes an administrative contract violation. In the case of an administrative contract violation,

procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(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, leases, 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 irrefutable presumption of relatedness through control or attribution of ownership or equity interests where the significance tests are met. The following persons are considered immediate family for cost-reporting purposes:

- (A) husband and wife;
- (B) natural parent, child, and sibling;
- (C) adopted child and adoptive parent;
- (D) stepparent, stepchild, stepsister, and stepbrother;
- (E) father-in-law, mother-in-law, 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, leases, or 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, leases, 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 actual reasonable costs, direct and indirect, incurred in the furnishing of services, equipment, facilities, leases, or 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 by convincing evidence to the satisfaction of HHSC 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, leases, 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, HHSC 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 HHSC, a copy of the applicable Medicare determination must accompany each written exception request submitted to HHSC, along with evidence supporting the Medicare determination for the current cost-reporting 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, HHSC may choose not to consider the Medicare determination. Written requests for an exception to the general rule applicable to related organizations must be submitted for approval to the HHSC Rate Analysis Department no later than 45 days prior to the due date of the cost report in order to be considered for that year's cost report. Each request must include documentation supporting that the contracted provider meets each of the four criteria listed in subparagraphs (A) - (D) of this paragraph. Requests that do not include the required documentation for each criteria will not be considered for that year's cost report.

(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, leases, 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, leases, 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, leases, 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, leases, 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, leases, 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 §355.105(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 this section and in §355.103 of this title apply.

(j) Cost allocation. Direct costing must be used whenever reasonably possible. Direct costing means that allowable costs, direct or indirect, (as defined in subsection (f)(3) - (4) of this section) incurred for the benefit of, or directly attributable to, a specific business component must be directly charged to that particular business component. For example, the payroll costs of a direct care employee who works across cost areas within one contracted program would be directly charged to each cost area of that program based upon that employee's continuous daily time sheets and the costs of a direct care employee who works across more than one service delivery area would also be directly charged to each service delivery area based upon that employee's continuous daily time sheets. Health insurance premiums, life insurance premiums, and other employee benefits must be direct costed.

(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 HHSC 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 HHSC for cost-reporting purposes.

(B) HHSC 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 §355.110 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) Providers must use an allocation method approved or required by HHSC. 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 and must be accompanied by a written explanation of the reasons and justification for such change. If the provider wishes to use an allocation method that is not in compliance with the cost-reporting allocation methods in paragraphs (3) - (4) of this subsection, the contracted provider must obtain written prior approval from HHSC's Rate Analysis Department.

(i) Requests for approval to use an allocation method other than those identified in paragraphs (3) - (4) of this subsection or for approval of a provider's change in cost-reporting allocation method other than those identified in paragraphs (3) - (4) of this subsection must be received by HHSC's 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 HHSC 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 HHSC 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 §355.110 of this title.

(iii) Failure to use an allocation method approved or required by HHSC or to disclose a change in an allocation to HHSC will result in the following.

(I) For nursing facilities, failure to disclose a change in an allocation method or failure to use the allocation method approved or required by HHSC may result in vendor hold as specified in §355.403 of this title.

(II) For Intermediate Care Facilities for Persons with Intellectual Disabilities (formerly known as Intermediate Care Facilities for Persons with Mental Retardation), Home and Community-based Services, Service Coordination/Targeted Case Management, Rehabilitative Services, and Texas Home Living programs, failure to use the allocation method approved or required by HHSC constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(III) For SHARS, failure to use the allocation method approved or required by HHSC constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.8443 of this title.

(IV) For all other programs, failure to disclose a change in an allocation method or failure to use the allocation method approved or required by HHSC constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(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 HHSC Rate Analysis Department prior to submitting a cost report utilizing the allocation method in question. Requests for approval must be received by the HHSC 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 HHSC 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, HHSC 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 §355.110 of this title.

(3) When a building is shared and the building usage is separate and distinct for each entity using the building, the building costs, identified as building and facility cost categories on the cost report, 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, identified as building and facility cost categories on the cost report, should be allocated using a reasonable method which reflects the actual usage, such as an allocation based on time in shared activity areas or a functional study of shared dietary costs related to 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 clause (i) of this subparagraph, 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 either:

(i) 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, with "facility or building costs" referring to those cost categories as identified on the cost report; or

(ii) based upon the labor costs method stated in subparagraph (B)(ii) of this paragraph.

(D) In order to achieve a more accurate and representative reporting of costs than results from allocating shared indirect costs as a pool of costs, a provider may choose to allocate its indirect shared expenses on an appropriate and reasonable functional basis. If allocating shared direct client care costs, a provider may use an appropriate and reasonable functional method. 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 number of purchases made or requisitions handled; payroll costs for an administrative employee working across business components could be directly charged based upon that employee's time sheets and/or allocated based upon a documented time study; food costs could be allocated based upon a functional study of shared dietary costs; transportation equipment costs could be allocated based upon mileage logs; and shared laundry costs could be allocated based upon a functional study of the number of pounds/loads of laundry processed. Providers choosing to allocate allowable employee-related self-insurance paid claims in accordance with §355.103(b)(13)(B)(ii) of this title should base the allocation on percentage of salaries of employees benefiting from the coverage for fully self-insured situations or on percentage of premiums of covered employees for partially self-insured situations since purchased premiums must be directly charged.

(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.

### 355.103 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 §355.102 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 audit fees. See subsection (b)(3)(A) of this section.
- (2) Advertising and public relations. See subsection (b)(16) of this section.
- (3) Amortization expense. See subsection (b)(10) of this section.
- (4) Bad debt expense. See subsection (b)(20)(M) of this section.
- (5) Boards of directors and trustees. See subsection (b)(5) of this section.
- (6) Bonuses. See subsection (b)(1)(A)(i) of this section.
- (7) Central office costs. See subsection (b)(7) of this section.
- (8) Charity allowance. See subsection (b)(20)(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 section.
- (11) Compensation of outside consultants. See subsection (b)(3) of this section.
- (12) Courtesy allowance. See subsection (b)(20)(N) of this section.
- (13) Depreciation expense. See subsection (b)(10) of this section.
- (14) Donated revenues. See subsection (b)(18) of this section.
- (15) Donated services, supplies, and assets. See subsection (b)(19) of this section.
- (16) Dues or contributions to organizations. See subsection (b)(14) of this section.
- (17) Employee relations expenses. See subsection (b) (20)(A) of this section.
- (18) Employment-related taxes. See subsection (b)(12)(B) of this section.
- (19) Endowment income. See subsection (b)(18) of this section.
- (20) Expenses not related to contracted services. See subsection (b)(20)(H) of this section.
- (21) Fines and penalties. See subsection (b)(20)(G) of this section.
- (22) Franchise tax. See subsection (b)(12)(C) of this section.

- (23) Finance charges. See subsection (b)(11)(E) of this section.
- (24) Franchise fees. See subsection (b)(20)(C) of this section.
- (25) Fringe benefits. See subsection (b)(1)(A)(iii) of this section.
- (26) Fundraising activities. See subsection (b)(17) of this section.
- (27) Gains on disposal of assets. See subsection (b)(10)(F) of this section.
- (28) Gifts. See subsection (b)(18) of this section.
- (29) Goodwill. See subsection (b)(10) and (20)(C)(ii) of this section.
- (30) Grants, gifts and income from endowments. See subsection (b)(18) of this section.
- (31) In-kind donations. See subsection (b)(19) of this section.
- (32) Insurance expense. See subsection (b)(13) of this section.
- (33) Interest expense. See subsection (b)(11) of this section.
- (34) Legal fees. See subsection (b)(3)(B) of this section.
- (35) Life insurance. See subsection (b)(13)(G) of this section.
- (36) Litigation expenses and awards. See subsection (b)(20)(I) of this section.
- (37) Lobbying costs. See subsection (b)(20)(J) of this section.
- (38) Losses on disposal of assets. See subsection (b)(10)(F) of this section.
- (39) Losses due to theft or embezzlement. See subsection (b)(20)(L) of this section.
- (40) Management fees. See subsection (b)(6) of this section.
- (41) Medicaid as payor of last resort. See subsection (b)(21) of this section.
- (42) Medical supplies and medical costs. See subsection (b)(20)(F) of this section.
- (43) Nonpaid workers. See subsection (b)(4) of this section.
- (44) Operating revenue. See subsection (b)(18)(D) of this section.
- (45) Organization costs. See subsection (b)(20)(B) of this section.
- (46) Payroll taxes and insurance. See subsection (b)(1)(A)(ii) of this section.
- (47) Penalties. See subsection (b)(20)(G) of this section.
- (48) Planning and evaluation expenses. See subsection (b)(10)(E) of this section.
- (49) Promotional activities. See subsection (b)(17) of this section.
- (50) Public relations. See subsection (b)(16) of this section.

- (51) Repairs and maintenance. See subsection (b)(9) of this section.
- (52) Research and development costs. See subsection (b)(20)(E) of this section.
- (53) Salaries and wages. See subsection (b)(1) and (2) of this section.
- (54) Self-insurance. See subsection (b)(13)(B) of this section.
- (55) Staff training costs. See subsection (b)(15)(A) of this section.
- (56) Startup costs. See subsection (b)(20)(D) of this section.
- (57) Tax expense and credits. See subsection (b)(12) of this section.
- (58) Travel costs. See subsection (b)(15)(B) of this section.
- (59) Utilities. See subsection (b)(8) of this section.
- (60) Volunteers. See subsection (b)(4) of this section.
- (61) Voucher-paid expenses. See subsection (b)(20)(K) of this section.
- (62) Workers' compensation insurance. See subsection (b)(13) 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 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 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 that 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) 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 (12) of this subsection, concerning tax expense and credits, and paragraph (13) of this subsection.

(iii) 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) 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, 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 benefits are reported on cost reports either as salaries and/or wages, as employee benefits, or as costs applicable to specific cost report line items, as specified in this subclause and in subclause (III) of this clause. Any benefit subject to payroll taxes is reported as salaries and wages. Allowable benefits that 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 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, uniforms, employee personal vehicle mileage reimbursement in accordance with paragraph (15) of this subsection, job-related training reimbursements in accordance with paragraph (15) of this subsection, and job certification renewal fees in accordance with paragraph (15) of this subsection are not to be reported as benefits but are to be reported as costs applicable to specific cost report line items, unless they are subject to payroll taxes, whereas they are reported as salaries and wages.

(III) Benefits include the following:

(-a-) Employer contributions to certain deferred compensation plans are reported as employee benefits. 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. To be allowable, contributions representing the employee's share cannot revert to the contracted provider. However employer-paid contributions can revert back to the contracted provider in the event an employee does not vest if designated in the requirements for vested benefits.

(-b-) Employer contributions to an employee retirement fund or certain pension plans are reported as employee benefits. 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 leave is reported as salaries or wages. 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 employer's interest are not to be reported as employee benefits, but are to be reported as costs related to specific cost report line items. Costs related to provider-paid instructional courses for the benefit of the employee only are unallowable costs. Refer to paragraph (15)(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 are not to be reported as employee benefits, but are to be reported as costs related to specific cost report line items. 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 are reported as employee benefits. Report allowable health, disability, and life insurance premium costs as employee benefits. Refer to paragraph (13) 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 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. This paragraph applies to the compensation of owners and related parties unless limits or caps on the compensation of owners and related parties are stated in the program specific rules, then those limits or caps take precedence.

(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 §355.102(i) of this title, 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 §355.105(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 that 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.

(3) 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 §355.102 of this

title. Specific criteria for certain types of compensation of outside consultants and contracted services are as follows:

(A) 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 (12) 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.

(B) Legal fees. Legal retainers are not allowable in and of themselves, but rather must be documented as specified in §355.105(b)(2)(B)(viii) of this title. 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.

(4) 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.

(5) Boards of directors and trustees. Fees and expenses related to boards of directors and trustees are unallowable costs except for:

(A) Travel costs incurred by the contracted provider's board members or trustees to attend meetings of the contracted provider's board of directors or trustees are allowable costs in accordance with the travel guidelines as stated in paragraph (15)(B) of this subsection; and

(B) Errors and omissions (liability) insurance for boards of directors or trustees are allowable costs.

(6) 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 §355.102(i) of this title 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.

(7) 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, leases, or supplies from its central office, the costs allowed are subject to the guidelines of related party transactions in §355.102(i) of this title. 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.

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

(9) 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 that 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 \$2,500 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.

(10) Depreciation and amortization expense. For DHS contracted providers: for purchases made after the beginning of the contracted provider's fiscal year 1997, 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. For purchases made after the beginning of the contracted provider's fiscal year 2004, an asset valued at \$2,500 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. For TDMHMR contracted providers: for purchases made after the beginning of the contracted provider's fiscal year

1997, an asset valued at \$2,500 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. For all contracted providers: for purchases made after the beginning of the contracted provider's fiscal year 2015, an asset valued at \$5,000 or more and with an estimated useful life of more than one year at the time of purchase must be depreciated or amortized, using the straight line method. In determining whether to expense or depreciate a purchased item, a contracted provider may expense any single item costing less than the capitalization level for that fiscal period as described above or having a useful life of one year or less. 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:

[Attached Graphic](#)

(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 the most current version of "Estimated Useful Lives of Depreciable Hospital Assets," published by the American Hospital Association. Copies of this publication may be obtained by contacting the American Hospital Association, 155 North Wacker Drive, Chicago, IL 60606 or at [www.aha.org](http://www.aha.org). 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 life of the leasehold improvement. 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. 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 (up to and including 15-passenger 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 §355.105(b)(2)(B)(iii) of this title 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, including automobiles, light trucks, and vans (up to and including 15-passenger vans) and 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, 1997. For vehicles leased or purchased on or after January 1, 1997, 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, 1998. 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 §355.105(b)(2)(B)(iv) of this title. 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 §355.105(b)(2)(B)(iii) of this title 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 2013 van were purchased in 2014, 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 2013 minivan were purchased in 2014, 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 five 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.

(11) 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. Refer to §355.104(5) of this title (relating to Revenues). 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 §355.105(b)(2)(B)(ii) of this title;

(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.

(12) 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 (FICA), Workers' Compensation and Unemployment Compensation, are allowable costs. Refer to paragraph (1) and (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; and

(vii) self-employment taxes.

(13) 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 subject to a cost ceiling in accordance with subparagraph (E)(i) - (iv) of this paragraph. Documentation substantiating the cost of comparable coverage by purchased and/or commercial insurance premiums must be obtained and maintained as specified in §355.105(b)(2)(B)(ix) of this title.

(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 §355.102(j) of this title.

(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 that is operated by a third party that assumes some of the risk and that 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. This cost ceiling is applied separately to employee-related insurance and to workers' compensation 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 §355.105(b)(2)(B)(ix) of this title.

(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) 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 subsection (b)(11) of this section.

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

(14) Dues or contributions to organizations.

(A) Allowable dues and contributions to organizations. Costs are allowable for membership in professional associations directly and primarily concerned with the provision of services for which the provider is contracted. 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 travel costs in accordance with paragraph (15)(B) of this subsection and reasonable registration fees and other costs incidental to those functions. Travel costs incurred by members of the board of directors of professional associations that are directly and primarily concerned with the provision of services for which the provider has contracted are allowable in accordance with paragraph (15)(B) of this subsection. 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 nonprofessional 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.

(15) 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 §355.105(b)(2)(B)(vi) of this title.

(ii) Staff training may be conducted within the provider setting or off-site. 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 Health and Human Services Commission (HHSC) 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 in-service 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 off-site 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 subparagraph (B) of this paragraph.

(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) For information regarding nursing facility nurse aide training, refer to paragraph (20)(K) of this subsection and program-specific reimbursement methodology rules.

(vi) For guidelines on allowability for 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 allowable activities 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; and

(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; the purpose of delivering direct contracted client services within 25 miles of the Texas border with adjoining states or Mexico; or the purpose for the travel is to conduct business related to contracted client services in Texas and the travel is between Texas and the contracted provider's central office. All costs for travel outside the continental United States are unallowable costs, with the singular exception of travel required for the delivery of direct contracted client services within 25 miles of the Texas-Mexico border.

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

(I) written documentation supporting the calculations for expenses for private aircraft and commercial alternatives, and flight logs are maintained as specified in §355.105(b)(2)(B)(iii) of this title; and

(II) the documentation demonstrates that the expenses for travel via private aircraft were not greater than those for commercial alternatives at the time the travel took place. If the expenses for private aircraft were greater than the documented costs for commercial alternatives at the time the travel took place, allowable private aircraft costs are limited to the documented costs for commercial alternatives.

(16) Advertising and public relations.

(A) Allowable advertising and public relations include:

(i) costs of advertising to meet statutory or regulatory requirements, such as program standards, rules, or contract requirements;

(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 §355.102(f)(2) of this title;

(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; and

(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 (10) of this subsection.

(B) Unallowable advertising and public relations include:

(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 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.

(17) 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.

(18) 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 §355.102(k) of this title for further guidelines on reporting net expenses.

(19) 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 subsection (b)(10) of this section. 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 1997 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 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 §355.102(j) of this title.

(B) Unallowable in-kind donations. The value of unallowable in-kind donations may be collected for specific programs at the discretion of HHSC 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.

(20) 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 (10) 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, 2014. Startup costs would be those costs incurred prior to April 4, 2014, which meet the above definition of startup costs. Amortization of the startup costs for this newly-formed business would begin April 2014. If this same corporation received a contract to provide Day Activity and Health Services (DAHS) effective October 1, 2014 and if the corporation served its first DAHS client on November 5, 2014, 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 2014), 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, 2014 (since the contract effective date occurred prior to serving the first DAHS client) would be amortized beginning with October 2014.

(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. For workers' compensation litigation awards and settlements, the part of the award or settlement that reimburses the injured employee for lost wages and medical bills is an allowable cost.

(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 the state legislature, or an employee of a member of Congress or the 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 that are involved in the regulation of contracted client care in the program with 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. Unless specifically exempted through program-specific reimbursement methodology rules, HHSC procedures or cost report instructions, any expenses directly reimbursable to the contracted provider that are considered outside the reimbursement payment system are unallowable costs. Such expenses include but are not limited to those associated with Medicare Part A and B ancillary services, HHSC voucher payment systems and vendor drug coverage. 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 the contracted provider or clients by the owners or employees of 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.

(21) Medicaid as payor of last resort. Medicaid is the payor of last resort. If a recipient has Medicare Part A or B benefits, other third party payor benefits, or any other benefits available those benefits must be accessed before Medicaid.

(22) For any individual eligible for Medicare Part D, the cost of any drug that is in a category that is covered by Medicare Part D is unallowable.

CORF – Comprehensive Outpatient Rehabilitation Facility  
ORF – Outpatient Rehabilitation Facility  
HHA – Home Health Agency  
DME – Durable Medical Equipment  
SHARS – School Health and Related Services  
MAC – Medicaid Administrative Claiming  
ASC – Ambulatory Surgical Center  
HASC – Hospital-based Ambulatory Surgical Center  
FQHC – Federally Qualified Health Center  
RHC – Rural Health Center  
IMD – Institution for Mental Disease  
NF – Nursing Facility  
ICF/IID – Intermediate Care Facility for Individuals with an Intellectual or Developmental Disability  
HCS – Home and Community-based Services  
TxHmL – Texas Home Living  
CLASS – Community Living Assistance and Service Supports  
CFC – Community First Choice  
MDCP – Medically Dependent Children Program  
DBMD – Deaf-Blind with Multiple Disabilities  
PHC – Primary Home Care  
CAS – Community Attendant Services  
FC – Family Care  
DAHS – Day Activities and Health Services  
RC – Residential Care  
MEI – Mental Health (M), Early Childhood Intervention (E), and Individuals with Developmental Disabilities (I) programs.  
SSLC – State Supported Living Center  
YES – Youth Empowerment Services  
HCS-AMH – Home and Community-based Services Adult Mental Health  
CRS-PABI – Community Rehabilitation Services – Post-Acute Brain Injury