DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

State Demonstrations Group

December 22, 2021

Stephanie Stephens
State Medicaid Director
Texas Health and Human Services Commission
4900 Lamar Boulevard
MC: H100
P.O. Box 13247
Austin, Texas 78751

Dear Ms. Stephens:

The Centers for Medicare & Medicaid Services (CMS) is approving the Public Health Providers Charity Care Pool (PHP-CCP) Payment Protocol for Demonstration Year (DY) 11 for Texas' section 1115(a) demonstration (Project number 11-W00278/6), entitled "Texas Healthcare Transformation and Quality Improvement Program (THTQIP)." For this demonstration, DY 11 is federal fiscal year 2022. The PHP-CCP Payment Protocol for DY 11 and associated Application Cost Report/Tool will be Attachment T to Special Terms and Conditions (STCs) of the THTQIP demonstration. As required by STC 39, this PHP-CCP Payment Protocol establishes the rules and guidelines for the state to claim federal financial participation (FFP) for the PHP-CCP for DY 11. The associated Application Cost Report/Tool for DY 11 collects information needed to determine the eligibility of providers to participate in the PHP-CCP and their eligible uncompensated costs.

Your project officer for this demonstration is Ms. Diona Kristian. She is available to answer any questions concerning your section 1115 demonstration. Ms. Kristian's contact information is:

Center for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-1102
E-mail: Diona.Kristian@cms.hhs.gov

Sincerely,

Angela D. Garner -S

Digitally signed by Angela D. Garner -S
Date: 2021.12.22 08:35:42 -05'00'

Angela D. Garner
Director, Division of System Reform Demonstrations

cc: Ford Blunt, State Monitoring Lead, Medicaid and CHIP Operations Group

Attachment T

Public Health Provider Charity

Care Program FFY 2022

Community Mental Health Centers

& Local Health Departments

For the PHP-CCP App/Cost Report

Provider Finance Department

May 2021

Table of Contents

Overview

The purpose of this document is to provide information regarding the Public Provider Charity Care Program (PHP-CCP) for federal fiscal year 2022. PHP-CCP is designed to allow qualified providers to receive reimbursement for healthcare service delivery costs when not reimbursed by another source. The healthcare services included are:

- Behavioral health services
- Immunizations
- Public health services
- Other preventative services

Authority

PHP-CCP is authorized under Section 1115 of the Social Security Act, otherwise known as *the 1115 Waiver*. In accordance with the Special Terms and Conditions of the 1115 Waiver, providers must be funded by a unit of government able to certify expenditures to participate in the program. Pursuant to 42 C.F.R. §433.51, entities with 501(c)(3) designation are not governmental entities and ineligible to participate in Certified Public Expenditure.

In accordance with Texas Health and Safety Code Chapters 533 and 534, the following publicly-owned and operated entities providing behavioral health services are eligible to participate:

- Community Mental Health Clinics (CHMCs)
- Community Centers
- Local Mental Health Authorities (LMHAs)
- Local Behavioral Health Authorities (LBHAs)

Additionally, under Title 2 Texas Health and Safety Code Chapter 121, the following publicly-owned and operated entities established under Chapter 121 are eligible to participate in the program:

- Local Health Departments (LHDs)
- Public Health Districts (PHDs)

Provider Reimbursement Qualification

The provider must be able to certify public expenditures to qualify for reimbursement. Certified public expenditures will be paid an annual lump sum based upon actual expenditures.

PHP-CCP Payments are considered Medicaid payments to providers and must be treated as Medicaid revenue when determining the total Title XIX funding received.

Cost Report Criteria

A provider must annually prepare and complete a Public Health Provider Cost Report according to the following criteria:

- The cost report must be submitted by the provider no later than 45 days after the close of the reporting period.
- The cost report period begins on October 1 and ends on September 30 of the following year.
- If a provider receives approval to participate in the PHP-CCP program after October 1, the cost report period begins on the effective date of the supplemental payment request approval.
- Costs are eligible for reimbursement for only 24 months after the date the cost was incurred.
- Completed cost reports must be sent via electronic mail or U.S. mail to the Texas Health and Human Services Commission (HHSC).
- **The cost report can only include allocable expenditures related to Medicaid, Medicaid Managed Care, and Uncompensated Care**. The Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program defines these expenditures as those pertaining to Medicaid, Medicaid Managed Care, and Uncompensated Care.
- The cost report **may not** include costs for services delivered to persons who are incarcerated at the time of the service.
- The cost report **may not** include costs for services delivered by an institution for mental diseases.
- Only complete the **shaded areas** of the cost report.

- Many worksheets, or *exhibits*, will automatically populate information provided in completed worksheets.

- Be sure to carefully review the information provided in the cost report before submission.

- Providers must attest to and certify its cost report of the total actual incurred Medicaid and Uncompensated (uninsured) costs and expenditures, including the federal share and the non-federal share applicable to the cost report period.

- The cost reporting guidelines will be governed by:

  - Title 1 Texas Administrative Code Section 355.101 (relating to Introduction);

  - Title 1 Texas Administrative Code Section 355.102 (relating to General Principles of Allowable and Unallowable Costs);

  - Title 1 Texas Administrative Code Section 355.103 (relating to Specifications for Allowable and Unallowable Costs);

  - Title 1 Texas Administrative Code Section 355.104 (relating to Revenues);

  - Title 1 Texas Administrative Code Section 355.105 (relating to General Reporting and Documentation Requirements, Methods, and Procedures);

  - Title 1 Texas Administrative Code Section 355.106 (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports);

  - Title 1 Texas Administrative Code Section 355.107 (relating to Notification of Exclusions and Adjustments);

  - Title 1 Texas Administrative Code Section 355.108 (relating to Determination of Inflation Indices);

  - Title 1 Texas Administrative Code Section 355.109 (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs); and

  - Title 1 Texas Administrative Code Section 355.110 (relating to Informal Reviews and Formal Appeals).

- During HHSC's desk review, providers will have to show documentation to demonstrate this information matches their submission and that the covered services are provided appropriately. Any additional information needed will be requested during the desk review.

For questions on completing the cost report, please contact the Health and Human Services Commission, Provider Finance Department at the email address: PHP-CCP@hhs.texas.gov.

Definitions

Charity Care

Healthcare services provided without expectation of reimbursement to uninsured patients who meet the provider's charity-care policy. The charity-care policy should adhere to the charity-care principles of the Healthcare Financial Management Association Principles and Practices Board Statement 15 (December 2019). Charity care includes full or partial discounts given to uninsured patients who meet the provider's financial assistance policy. Charity care does not include bad debt, courtesy allowances, or discounts given to patients who do not meet the provider's charity-care policy or financial assistance policy.

Cognizant Agency

Agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals developed in accordance with the Office of Management and Budget Circular A-87.

Cost Allocation Plans

The means by which costs are identified in a logical and systematic manner for reimbursement under federal grants and agreements.

Cost-to-Charge Ratio

A provider's reported costs are allocated to the Medicaid program based on a cost-to-charge ratio. Cost-to-charge ratio is calculated as the Total Allowable Cost reported for the service period to represent the numerator of the ratio to the billed charges of the total all claims for the service period that represents the denominator of the ratio (see below). This ratio is applied to calculate total billed charges associated with Medicaid paid claims or total computable amount for the cost report.

$$\text{Cost-to-Charge Ratio} = \frac{\text{Total Allowable Cost Reported}}{\text{Billed Charges of All Claims}}$$

Direct Cost

This term refers to any cost explicitly associated with a particular final cost objective. Direct costs are not limited to items incorporated in the end product as material or labor. Costs identified specifically with a contract are direct costs of that contract. All costs identified specifically with other final cost objectives of the contractor are direct costs of those cost objectives.

Federal Medical Assistance Participation (FMAP) Rate

The share of state Medicaid benefit costs paid for by the federal government.

Indirect Costs

These are costs incurred identified with two or more cost objectives but not specifically identified with any final cost objective.

Medicaid Fee-For-Service (FFS) Paid Claims

These claims are Medicaid payments made by HHSC through the Texas Medicaid Healthcare Partnership to enrolled providers for services provided to Medicaid recipients.

Medicaid Managed Care

Medicaid Managed Care delivers Medicaid health benefits and additional services through an arrangement between a state Medicaid agency and managed care organizations (MCOs) that accept a set payment for these services. Medicaid payments are made by the MCOs to providers for services provided to Medicaid recipients.

Medicare

Medicare is a federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.

Other Third-Party Coverage:

Commercial Pay Insurance:

Commercial Pay Insurance is health insurance that covers medical expenses and disability income for the insured. Commercial health insurance can be categorized

according to its renewal provisions and the type of medical benefits provided. Commercial policies can be sold individually or as part of a group plan.

Self-Pay:

A self-pay patient pays in full at the time of visit for services and does not file a claim with an insurance carrier.

Total Computable Amount

The Total Computable Amount is the total Medicaid allowable amount payable for services.

Uncompensated Care (UC)

Healthcare provided for which a charge was recorded, but no payment was received. UC consists of two components: (1) charity care, in which the patient is unable to pay, and (2) bad debt, in which payment was expected but not received. Uncompensated care excludes other unfunded costs of care, such as underpayment from Medicaid and Medicare.

Uninsured

An individual who has no health insurance or other source of third-party coverage for medical/health services.

Uninsured Cost

Uninsured Cost is the cost to provide services to uninsured patients as defined by the Centers for Medicare and Medicaid Services (CMS). An individual whose third-party coverage does not include the service provided is considered by HHSC to be uninsured for that service.

Unit of Government

A state, city, county, special purpose district, or other governmental units in the State that: has taxing authority, direct access to tax revenues, is a State university teaching hospital with direct appropriations from the State treasury, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act, as amended, 25 U.S.C. 450b.

Exhibit A: Cost Report Cover Page

Exhibit A is the cost report cover page. This form includes a provider's National and State Provider Identification Number used by HHSC to obtain the fee-for-service cost data included in the cost report. Each government entity must enter information for its entity, including the:

- entity's Legal name;
- name of the person responsible for submitting the cost report;
- name of the cost report preparer;
- name of the person responsible for making financial decisions on behalf of the organization, if different than the preparer; and
- the physical location, mailing address, phone number, fax number, and email address of all contacts listed.

HHSC will use the information to contact the provider as necessary throughout the cost reconciliation and cost settlement process.

DIRECTIONS TO COMPLETE EXHIBIT A:

Reporting Period

Enter the actual **Reporting Period** for which the cost report will be completed (e.g., 10/01/10 to 09/30/11).

Primary Texas Provider Identification Number (TPI)

Enter the main **9-digit TPI** number for the provider completing the cost report (e.g., 123456789).

Primary National Provider Identification Number (NPI)

Enter the main **10-digit NPI** number for the provider completing the cost report (e.g., 1234567890).

Associated Texas Provider Identification Numbers (TPIs)

Enter the other associated **9-digit TPI** numbers for the provider completing the cost report (e.g., 123456789, 987654321, 012345678, etc.).

Associated National Provider Identification Number (NPIs)

Enter the other associated **10-digit NPI** numbers for the provider completing the cost report (e.g., 1234567890, 0123456789, 1231231230, etc.).

Provider Information

Provider Legal Name:

Enter the **Provider Legal Name** (e.g., Health and Human Services Commission EMS). The name of the provider completing the cost report should be listed here.

Street Address:

Enter the provider's **Street Address** (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78758). Include the city, state, and zip code in this field.

Mailing Address:

Enter the provider's **Mailing Address** (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78758 or P.O. Box 85700, Mail Code H-400, Austin, TX 78708-5200). Include the city, state, and zip code in this field.

Phone Number:

Enter the **Phone Number** of the provider's contact (e.g., (512) 123-4567).

Fax Number:

Enter the **Fax Number** of the provider's contact (e.g., (512) 987-6543).

Email Address:

Enter the **Email** address of the provider's contact (e.g., iampublic@xyzabc.com).

Business Manager or Financial Director

Business Manager or Financial Director's Name:

Enter the **Name** of the provider's business manager or financial director (e.g., Jane Doe).

Title:

Enter the **Title** of the provider's business manager or financial director identified in the field above (e.g., Director).

Agency Name:

Enter the name of the agency or municipality or provider submitting the cost report.

Mailing Address:

Enter the provider's **Mailing Address** (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78758 or P.O. Box 85700, Mail Code H-400, Austin, TX 78708-5200). Include the city, state, and zip code in this field.

Phone Number:

Enter the **Phone Number** of the provider's contact (e.g., (512) 123-4567).

Fax Number:

Enter the **Fax Number** of the provider's contact (e.g., (512) 987-6543).

Email Address:

Enter the **Email** address of the provider's contact (e.g., jqpublic@xyzabc.com).

Report Preparer Identification

Report Preparer Name:

Enter the **Name** of the provider's contact or person responsible for preparing the cost report (e.g., Jane Doe). HHSC may contact the individual if there are questions.

Title:

Enter the **Title** of the provider's contact identified in the field above (e.g., Director).

Mailing Address:

Enter provider's **Mailing Address** (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78758 or P.O. Box 85700, Mail Code H-400, Austin, TX 78708-5200). Include the city, state, and zip code in this field.

Phone Number:

Enter the **Phone Number** of the provider's contact (e.g., (512) 123-4567).

Fax Number:

Enter the **Fax Number** of the provider's contact (e.g., (512) 987-6543).

Location of Accounting Records that Support this Report

Records Location:

Enter the **physical address** of the location where the provider maintains the accounting records in support of the cost report (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78781). Include the city, state, and zip code in this field.

Exhibit 1: General and Statistical Information

Exhibit 1 is the General and Statistical Information page of the cost report. This exhibit includes general provider information and statistical information.

DIRECTIONS TO COMPLETE EXHIBIT 1

General Provider Information

Reporting Period – Begin Date:

Enter the **Reporting Period – Beginning** date or the beginning date of the cost report period (e.g., 10/1/2010).

Reporting Period – End Date:

Enter the **Reporting Period – Ending** date or the ending date of the cost report period (e.g., 9/30/2011).

Part-Year Cost Report:

Enter an answer to the question "**Is Reporting Period less than a full year?**" This question identifies if the cost report is being prepared for a period that is not an entire fiscal year. If the cost report is for an entire fiscal year (October 1 to September 30), then enter **No** in the field. If the cost report is being prepared for a partial fiscal year, enter a response that explains the reason why (e.g., Supplemental Payment Request Approval was effective beginning on 7/1/20XX).

Statistical Information

This cost report uses a cost-to-billed charge ratio methodology applied to determine the portion of costs eligible for reimbursement under the Direct Medical settlement exhibit (*see* Exhibit 2).

Summary of Payments and Billed Charge Data (Applicable to Cost Report)

Medicaid Fee for Service Paid Claims Amount:

Enter the **Total Medicaid fee-for-service (FFS) Paid Claims Amount** for the applicable cost report period identified on the form associated with the NPI and TPI

identified in Exhibit A. The Medicaid fee-for-service paid claims amount entered must only be for **dates of service** during the cost report period.

Total Billed Charges Associated with Medicaid FFS Paid Claims:

Enter the **Total Billed Charges associated with Medicaid FFS Paid Claims** for the applicable cost report period identified on the form. The total billed charges associated with Medicaid FFS paid claims entered must only be for **dates of service** during the cost report period. Billed charges are based on the local chargemaster that sets the usual and customary rate for services.

Medicaid Managed Care Organization (MCO) Paid Claims Amount:

Enter the total **MCO** Paid Claims Amount for services provided for the applicable Cost Report period identified on the form. The Medicaid MCO paid claims amount for services entered should be for dates of service during the cost report period.

Total Billed Charges Associated with MCO Paid Claims:

Enter the **Total Billed Charges associated with Medicaid MCO Paid Claims** for the applicable cost report period identified on the form. The total billed charges associated with MCO paid claims entered must only be for **dates of service** during the cost report period. Billed charges are based on the local chargemaster that sets the usual and customary rate for services.

Uninsured/Uncompensated Care (UC) Reimbursements Received Associated with UC Claims:

Enter the **reimbursements received associated with UC Claims** for the applicable cost report period identified on the form. The total reimbursements received associated with UC claims entered must only be for **dates of service** during the cost report period.

Uninsured/Uncompensated Care (UC) Uninsured Charges:

Enter the total **UC** Charity and Bad Debt charges for services provided for the applicable Cost Report period identified on the form. The UC charges entered should be for dates of service during the cost report period and must exclude all unfunded Medicaid and Medicare costs. Billed charges are based on the local chargemaster that sets the usual and customary rate for services.

Grants/Donations/Appropriations Paid for Direct Medical Services:

Enter the total **Grants/Donations/Appropriations Paid for Direct Medical Services** provided for the applicable cost report period identified on the form. The amount entered should be for dates of service during the cost report period. Note that the amount should reflect funds used to pay for direct medical services and that these funds are reported separately from the funds directly related to payroll and positions (entered in Exhibit 6). Note that the amount is also separate from Uninsured/Uncompensated Care (UC) Reimbursements Received Associated with UC Costs.

Total Billed Charges Associated with Grants/Donations/Appropriations Paid for Direct Medical Services:

Enter the **Total Billed Charges Associated with Grants/Donations/Appropriations Paid for Direct Medical Services** for the applicable cost report period identified on the form. The total billed charges associated entered must only be for **dates of service** during the cost report period. Billed charges are based on the local chargemaster that sets the usual and customary rate for services.

Total Allowable Costs for Reporting Period:

The **Total Allowable Costs** calculated are for the applicable cost report period identified on the direct service tab. The total allowable costs are only for dates of service during the cost report period.

Total Billed Charges for Reporting Period:

The **Total Billed Charges** calculated are for the applicable cost report period identified on the form, less the total allowable costs and less any reimbursements received. The total billed charges entered are only for dates of service during the cost report period.

Additional Statistical Information:

In addition to the statistical information entered for the Cost Reporting period, other cost data is required.

Medicare Charges:

Enter the total **Medicare Charges** for services provided for the applicable cost report period identified on the form. The Medicare charges for services entered should be for dates of service during the cost report period.

Self-Pay, County, or City Indigent Recipient Program Charges:

Enter the total **Self-pay or County or City Indigent Charges** for services provided for the applicable cost report period identified on the form. The "other" charges for services entered should be for dates of service during the cost report period.

Other Third-Party Insurance Coverage Charges:

Enter the total **Other Third-party Coverage Commercial Pay** Charges for services provided for the applicable cost report period identified on the form. The "other" charges for services entered should be for dates of service during the cost report period.

Exhibit 2: Direct Medical

Exhibit 2 identifies and summarizes all service costs within the cost report from other exhibits. Much of the information contained within this exhibit is pulled from either Exhibit 5 or Exhibit 6. However, unique cost items are identified in this exhibit.

Only allocable expenditures related to Medicaid FFS, Medicaid Managed Care, and Uncompensated Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program will be included for supplemental payment(s).

This exhibit provides a sum of the personnel expenses and adds additional costs to calculate the total cost of Medical and Uncompensated Care Services.

Direct Cost Methods

Direct Cost methods must be used. Direct Cost means that allowable costs for medical services for the benefit of, and directly attributable to, a specific service delivery component must be charged directly to that business component. Providers may use reasonable cost allocation methods for operational costs related to direct service delivery.

Supplemental Schedule

The amounts from the supplemental schedule allocated to the Medicaid and Uncompensated Care programs should match the amounts entered on the following forms:

- Exhibit 6, Schedule B.
- Exhibit 7, Schedule C - Cost Allocation Methodologies Employed by the provider (additional detail is entered here).
- Exhibit 8, Schedule D - Collections Tracking Form, if applicable.
- Other forms or reports used to track and calculate Uncompensated Care costs may be used in place of Exhibit 8, Schedule D.

The provider must fully disclose any change in cost-reporting allocation methods from one year to the next on its cost report.

Identified Reductions

As part of the cost report, identified reductions from Exhibit 1 and Exhibit 6 are subtracted to calculate the settlement amount. The cost report identifies the portion of allowable costs related to:

- Medicaid FFS
- Medicaid Managed Care
- Uncompensated Care

Cost-to-Charge Ratio

The cost-to-charge ratio for the applicable cost report period is for all billed charges incurred by the facility regardless of payer resulting in the total computable amount for services. That amount is then reduced by the amount of Medicaid FFS, Medicaid Managed Care paid claims, and any reimbursement received for Uncompensated Care. The resulting amount is then multiplied by the applicable federal medical assistance percentage to calculate the amount of settlement due to or owed by (if negative) the provider.

$$\textbf{Cost-to-Charge Ratio} = \frac{\text{Total Allowable Cost Reported}}{\text{Billed Charges of All Claims}}$$

Medicaid and Uninsured Cost = Cost-to-Charge Ratio x Total Billed Charges Associated with Medicaid and Uninsured Cost Claims

Settlement Amount = Medicaid and Uninsured Cost – Medicaid Payments and Uninsured Fees Collected

Amount Due to Provider = Settlement Amount x FMAP Percentage

Exhibit 2 Sections

Exhibit 2 is separated into the sections identifying:

- **Personnel or Payroll Expenses.** This section of the exhibit includes, in part, expenditures from Exhibit 6.
- **Other Operating Costs.** This section of the exhibit includes, in part, expenditures from Exhibit 5.

- **Reductions to Allowable Costs.** This section of the exhibit includes reductions to expenditures identified in Exhibit 6.
- **Cost Settlement Calculation.** This section applies the cost-to-charge ratio calculation methodology to arrive at the final settlement due to or from the provider.

DIRECTIONS TO COMPLETE EXHIBIT 2

Personnel or Payroll Expenses

This section of the exhibit includes all personnel-related expenditures and hours for the job classifications identified.

Hours:

Enter the number of **Hours** for each of the job classifications identified in this exhibit and for which costs are identified in Exhibit 6. Hours for this exhibit represent total paid hours that are reported by the provider on payroll reports. Total paid hours include, but are not limited to:

- regular wage hours,
- sick hours, and
- vacation hours.

Payroll Taxes or Unemployment Compensation

If applicable, enter the amount of the following payroll expenses:

- State Unemployment Payroll Taxes
- Federal Unemployment Payroll Taxes
- Unemployment Compensation (Reimbursing Employer)

Other Operating Costs

This section of the exhibit identifies other operating costs not related to the job classifications identified above. Within this section, Support Services or Other may include personnel-related expenditures not identified in the job classifications in the section above.

All costs identified in this section of the exhibit are supported by supplemental schedules to the cost report and will be supplied at the time of cost report submission.

Supplies, Materials, and Equipment Costs:

Enter the amount of **Supplies and Materials,** and **Equipment** expenditures incurred by the provider during the cost report period. Please see Appendix A with examples of supplies, materials, and equipment. Supplies and materials include, but are not limited to:

- medical supplies,
- office supplies,
- maintenance supplies, and
- medical materials.

Support Services Costs:

Enter the amount of **Support Services** expenditures incurred by the provider during the cost report period. Support Services expenditures may include personnel and non-personnel expenditures if the personnel expenditures are represented in the job classification categories identified in this exhibit and detailed in Exhibit 6. Support Services expenditures include, but are not limited to, information technology salaries, benefits, and operating expenditures.

Depreciation Expense:

All assets must be depreciated. Asset costs are only accepted on the Cost Report if the asset is depreciated in accordance with the Medicare cost report requirements. If the item is not depreciable pursuant to the Medicare requirements, prior approval from HHSC and CMS is required before recording the entry on the Cost Report.

Other Costs:

Enter the amount of **Other** expenditures incurred by the provider during the Cost Report period. Other expenditures may include personnel and non-personnel expenditures if the expenditures are represented in the job classification categories identified in this exhibit and detailed in Exhibit 6.

Allocation Ratio:

Enter the number of **Medical Clients Served** by the provider during the Cost Report period. Enter the number of **All Clients Served** by the provider during the Cost Report period, both medical and non-medical. The **Allocation Ratio** is calculated by dividing the medical clients served over all clients served. The total direct other costs is multipled by the allocation ratio to get the **Total Direct Medical Other Costs**.

Because all costs must be related to Medicaid covered services and providers offer a variety of services, HHSC may require a provider to use a separate allocation mechanism for the Allocation Ratio that more accurately allocates direct and indirect costs. Further, at a provider's request, HHSC may allow for a separate allocation mechanism for the Allocation Ratio that more accurately allocates direct and indirect costs, so long as the provider is able to provide support and justification.

Reductions to Allowable Costs

This section of the exhibit includes reductions to expenditures identified in Exhibit 1 and Exhibit 6. Identified reductions from Exhibit 1 and Exhibit 6 are subtracted to calculate the adjusted amount of Direct Medical Costs allowable as part of the cost report.

Cost Settlement Calculation

Period of Service for Applicable Cost Report Period: Enter the **Period of Service** for the applicable cost report period. Example: 10/01/20XX to 09/30/20XX. For partial year cost reports, enter the period of service applicable only to the time frame a cost report is submitted to cover.

Total Billed Charges for Period of Service:

The **Total Billed Charges** for the applicable period of service. (No entry is required).

Total Allowable Costs for Period of Services:

The total allowable costs entered into the cost report, less any "other federal funding" received. (No entry is required).

Cost-to-Charge Ratio:

This ratio is the result of dividing a provider's Total Allowable Costs for the reporting period by the provider's Total Billed Charges for the same period.

$$\text{Cost to Charge Ratio} = \frac{\text{Total Allowable Costs}}{\text{Provider's Total Billed Charges}}$$

Total Charges Associated with Medicaid, Paid Claims, Medicaid Managed Care Claims, and Uncompensated Care Paid Fees:

Enter the **Total Billed Charges Associated with Medicaid FFS and Medicaid Managed Care Paid Claims** for the period of service applicable to the cost report. (No entry is required).

Total Computable

The total Medicaid Allowable Costs for the period of service applicable to the cost report. The **Total Computable** amount is reduced by the amount of Medicaid Claims paid (Interim Payments) by a provider for the service period applicable to the cost report. This calculation is equal to the **Settlement Amount** for the reporting period. (No entry is required).

Exhibit 3 – Cost Report Certification

Exhibit 3 is the Certification of costs included in the cost report. This form attests to and certifies the accuracy of the financial information contained within the cost report.

DIRECTIONS TO COMPLETE EXHIBIT 3

Most of the information in Exhibit 3 will be updated automatically with information from previous exhibits. This exhibit must be signed and included **UPON COMPLETION OF ALL OTHER EXHIBITS**.

Upon completion of all other exhibits in the cost report, please **print this exhibit, sign the exhibit, have the form notarized, scan the exhibit, and include the signed exhibit** when sending the electronic version of the cost report to HHSC. Please be sure the form is read and signed by the provider or a representative with authority to sign on behalf of the provider.

Preparer Identification

Preparer or Contractor Name:

Enter the **Name** of the person that will prepare or has prepared the cost report (e.g., Jane Doe).

Title:

Enter the **Title of Signer**, or the title of the person that will prepare or has prepared the cost report (e.g., Director).

Vendor/Company Name:

Enter the **Name of the Company or Business** with whom the report preparer/contractor is affiliated.

Signature Authority or Certifying Signature

Certifier Name:

Enter the **Name of** the person that will be certifying the costs identified in the cost report (e.g., Jane Doe).

Title:

Enter the **Title of Signer** or the title of the person that will be certifying the costs identified in the cost report (e.g., Director).

Print:

Please print this exhibit and have the appropriate person identified above sign the certification form.

Date:

Enter the **Date** that the appropriate person identified above signs the certification form (e.g., 1/1/2011).

Signature Authority Check Box:

Check the appropriate box that corresponds to the person signing this exhibit.

Notary:

Upon printing and signing this exhibit, please have this form **Notarized**.

Exhibit 4 – Certification of Funds

Exhibit 4 is the Certification of Public Expenditure. It allows the State to use the computable Medicaid expenditures as the non-federal match of expenditures to draw the federal portion of Medicaid funding as identified in the settlement. This form attests to and certifies the following:

- The accuracy of the financial information provided.
- The report was prepared in accordance with State and Federal audit and cost principle standards.
- The costs have not been claimed on any other cost report for federal reimbursement purposes.
- This exhibit also identifies the amount of local provider expenditure allowable for use as the State match.

DIRECTIONS TO COMPLETE EXHIBIT 4

Most of the information in Exhibit 4 will be updated automatically with information from previous exhibits. This exhibit must be signed and included **UPON COMPLETION OF ALL OTHER EXHIBITS**.

Upon completion of all other exhibits in the cost report, please **print this exhibit, sign the exhibit, have the form notarized, scan the exhibit, and include the signed exhibit** when sending the electronic version of the cost report to HHSC. Please be sure the form is read and signed by the provider or a representative with authority to sign on behalf of the provider.

Signature Authority/Certifying Signature

Print:

Please print this exhibit and have the appropriate person sign the certification form.

Date:

Enter the **Date** that the appropriate person identified above signs the certification form (e.g., 1/1/2011).

Certifier Name:

Enter the **Name of Signer**, or the person that will be certifying the public expenditures identified in the cost report (e.g., Jane Doe).

Title:

Enter the **Title of Signer**, or the title of the person that will be certifying the public expenditures identified in the cost report (e.g., Director).

Certifier Check Box:

Check the appropriate box that corresponds to the title of the person signing this exhibit. If **Other Agent/Representative** is selected, please include the appropriate title.

Notary:

Upon printing and signing this exhibit, please have this form **Notarized**.

Exhibit 5 – Schedule A (Depreciation Schedule)

Exhibit 5 identifies allowable depreciation expenses incurred by the provider related to Medicaid, Medicaid Managed Care, and Uncompensated Care. This exhibit will identify depreciable assets for which there was a depreciation expense during the Cost Report period. Information on this exhibit must come from a depreciation schedule maintained by the provider in accordance with appropriate accounting guidelines established by the provider. For depreciation expenses, the straight-line method should be used. Prior Period Accumulated Depreciation plus Depreciation for Reporting Period cannot exceed the total cost of an asset. In addition, assets that have been fully expensed should not be reported.

DIRECTIONS TO COMPLETE EXHIBIT 5

Vehicles: Depreciation of vehicles is limited to only the vehicles used in the delivery and/or transportation of recipients to and from a Title XIX medical service. No other vehicles are to be included in the costing or depreciation application for this pool payment.

For depreciation expenses related to vehicles, the provider must follow Medicare depreciation instructions. The vehicle depreciation expense as reported on the Cost Report must come from the provider's depreciation schedule.

Asset Description:

Enter the **Description of the Asset** that will be included in this depreciation schedule. The name or account code, or both, will suffice. If there is the need to add additional lines, please do so.

Month/Year Placed in Service:

Enter the **Month/Year Placed in Service** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was first put into service.

Years Useful Life:

Enter the number of **Years of Useful Life** of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost:

Enter the amount of the initial **Cost** of the asset identified on the provider's depreciation schedule.

Salvage Value:

Enter the value of the asset after depreciation has been fully expensed.

Prior Period Accumulated Depreciation:

Enter the amount of **Prior Period Accumulated Depreciation** related to the asset as identified on the provider's depreciation schedule. This amount is the total depreciable expenses to date, related to the depreciable asset.

Month/Year of Disposal:

Enter the **Month/Year of Disposal** identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was removed from service.

Depreciation for Reporting Period:

The calculated amount of current period depreciation expense is the **HHSC Allowable Depreciation**. This amount is the total depreciable expense incurred during the Cost Report period.

Equipment

For depreciation expenses related to equipment, the provider must follow Medicare depreciation instructions. The equipment depreciation expense reported on the Cost Report must come from the provider's depreciation schedule.

Asset Description:

Enter the **Description of the Asset** that will be included in this depreciation schedule. The name or account code, or both, will suffice. If there is the need to add additional lines, please do so.

Month/Year Placed in Service:

Enter the **Month/Year Placed in Service** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was first put into service.

Years Useful Life:

Enter the number of **Years of Useful Life** of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost:

Enter the amount of the initial **Cost** of the asset identified on the provider's depreciation schedule.

Salvage Value:

Enter the value of the asset after depreciation has been fully expensed.

Prior Period Accumulated Depreciation:

Enter the amount of **Prior Period Accumulated Depreciation** related to the asset as identified on the provider's depreciation schedule. This amount is the total depreciable expenses to date related to the depreciable asset.

Month/Year of Disposal:

Enter the **Month/Year of Disposal** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was removed from service.

Depreciation for Reporting Period:

The calculated amount of current period depreciation expense in the **HHSC Allowable Depreciation**. This amount is the total depreciable expense incurred during the Cost Report period.

Building

For depreciation expense related to buildings where the provider's vehicles or staff are housed with other agencies or entities, **ONLY the portion related to the provider** may be reported, and the provider must follow Medicare depreciation instructions. The provider must attach a supplemental exhibit showing how the portion of the building related to the provider was calculated.

Asset Description:

Enter the **Description of the Asset** that will be included in this depreciation schedule. The name or account code, or both, will suffice. If there is the need to add additional lines, please do so.

Month/Year Placed in Service:

Enter the **Month/Year Placed in Service** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was first put into service.

Years of Useful Life:

Enter the number of **Years of Useful Life** of the asset as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost:

Enter the amount of the initial **Cost** of the asset identified on the provider's depreciation schedule.

Salvage Value:

Enter the value of the asset after depreciation has been fully expensed. For buildings, this amount is 10% of the building cost.

Prior Period Accumulated Depreciation:

Enter the amount of **Prior Period Accumulated Depreciation** related to the asset as identified on the provider's depreciation schedule. This amount is the total depreciable expenses to date, related to the depreciable asset.

Month/Year of Disposal:

Enter the **Month/Year of Disposal** as identified on the provider's depreciation schedule (e.g., January 2000, or 1/2000). This date is the month and the year that the depreciable asset was removed from service.

Depreciation for Reporting Period:

The calculated amount of current period depreciation expense in the **HHSC Allowable Depreciation**. This amount is the total depreciable expense incurred during the Cost Report period.

Exhibit 6 – Worksheet B (Payroll and Benefits)

This exhibit includes the salary and benefits and appropriate reductions related to contracted and employed staff of the provider for Medicaid, Medicaid Managed Care, and Uncompensated Care. For this exhibit, all employed and contracted staff related to the provision of direct medical services should be identified here. HHSC may pre-populate certain staffing classifications for which information will need to be completed. Any payroll related item that is not directly related to medical services should not be included in this section.

DIRECTIONS TO COMPLETE EXHIBIT 6

Employee Information

This section of the exhibit is designed to identify employee information for the specific job classifications identified. This section of the exhibit is also intended to discretely identify the employee information for any individual employee or contractor that must have a portion of their salaries or benefits, or both reduced from allowable expenditures on the Cost Report.

For each of the job classifications identified, the following information must be included:

Employee #:

Enter the **Employee #** for the employee for which a portion of their salary or benefits, or both must be reduced from the total allowable costs.

Last Name:

Enter the **Last Name** of the employee for which a portion of their salary or benefits, or both must be reduced from the total allowable costs.

First Name:

Enter the **First Name** of the employee for which a portion of their salary or benefits, or both must be reduced from the total allowable costs.

Job Title/Credentials:

Enter the **Job Title/Credentials** of the employee for which a portion of their salary or benefits, or both must be reduced from the total allowable costs.

Employee (E) or Contractor (C):

Enter the appropriate designation, **either an E or C,** of the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. E designates an employee; C designates a contractor.

Payroll and Benefits

This section of the exhibit is designed to identify payroll and benefit expenditures for the specific job classifications identified. This section of the exhibit is also intended to discretely identify the payroll and benefit expenditures for any individual employee/contractor that must have a portion of their salary or benefits, or both reduced from allowable expenditures on the Cost Report.

For each of the job classifications identified, the following information must be included:

Gross Salary:

Enter the **Gross Salary** amount for the employee for which a portion of his or her salary or benefits, or both must be reduced from the total allowable costs.

Contractor Payments:

Enter the amount of **Contractor Payments** for the employee for which a portion of his or her salary or benefits, or both must be reduced from the total allowable costs.

Employee Benefits:

Enter the amount of **Employee Benefits** for the employee for which a portion of his or her salary or benefits, or both must be reduced from the total allowable costs. This includes all benefits that are not discretely identified this exhibit.

Employer Retirement:

Enter the amount of **Employer Retirement** expenditure for the employee for which a portion of his or her salary or benefits, or both must be reduced from the total allowable costs.

FICA:

Enter the employer portion amount of **FICA** expenditure for the employee for which a portion of his or her salary or benefits, or both must be reduced from the total allowable costs.

Payroll Taxes:

Enter the employer portion amount of **Other Payroll Taxes** expenditure for the employee for which a portion of his or her salary or benefits, or both must be reduced from the total allowable costs.

Federal Funding Reductions

This section of the exhibit is designed to identify the federal funding or other payroll and benefit expenditure reduction necessary for the specific job classifications identified. This section of the exhibit is intended to discretely identify the payroll and benefit expenditures for any individual employee/contractor that must have a portion of his or her salary or benefits, or both, reduced from allowable expenditures on the Cost Report.

For each of the job classifications identified, the following information must be included:

Allocated Funded Positions Entry:

Enter the appropriate designation, **either a Y or a N**, for the employee for which a portion of his or her salary or benefits, or both, must be reduced from the total allowable costs. A "Y" in this field designates an employee for which a portion or all of his or her salary and benefit expenditures are funded by federal funds or grants. A "N" in this field designates an employee for which a portion or all of his or her salary and benefit expenditures are not funded by federal funds or grants but still need to be removed from allowable expenditures, as reported on the Cost Report.

Federal Funding:

If the answer to the field previously is "Y," then enter the amount of **Federal Funding** related to the employee's salary and benefits that must be reduced from the total allowable costs, as reported on the Cost Report.

Other Funds:

Enter the amount of **Other Amount to be Removed** related to the employee's salary and benefits that must be reduced from the total allowable costs, as reported on the Cost Report.

Supplemental Schedule:

A provider may enter information on a summary basis rather than entering each employee individually if a supplemental personnel schedule is provided.

Exhibit 7-Schedule C – Cost Allocation Methodologies

This exhibit is designed to include detailed cost allocation methodologies employed by the provider.

- Does your agency have a Cost Allocation Plan (CAP)? If so, please provide a copy of your agency's proposed CAP. If not, enter in detail the allocation methodology that will be used for allocating costs on the cost report.

- Please provide a list of personnel cost worksheets that support your CAP. Attach the Detailed Explanation Externally.

Exhibit 8-Schedule D – Reasonable Collections Effort Tracking Form

REASONABLE COLLECTION EFFORT

To be considered a reasonable collection effort, a provider's effort to collect fees for services rendered must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters, telephone calls, or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment.

If a separate Texas Administrative Code (TAC) rule does not allow for providers to collect fees from clients, providers must provide this reasoning in place of this documentation.

Collection Agencies

A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone, and personal contacts. Where a collection agency is used, it is expected that the provider refers all uncollected patient charges of like amount to the agency without regard to the class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.

Documentation Required

The provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc. During HHSC's desk review, a provider will have to show documentation to demonstrate this information matches their submission and that the covered services are provided appropriately. Any additional information needed will be requested during the desk review.

Collection Fees

Where a provider utilizes the services of a third party, non-related collection agency, and the reasonable collection effort is applied, the fees the collection

agency charges the provider are recognized as an allowable administrative cost of the provider.

When a collection agency obtains payment of an account receivable, the full amount collected must be credited to the patient's account, and the collection fee charged to administrative costs. For example, if an agency collects $40 from the patient/responsible party, and its fee is 50 percent, the agency keeps $20 as its fee for the collection services and remits $20 (the balance) to the provider. The provider records the full amount collected from the patient by the agency ($40) in the patient's account receivable and records the collection fee ($20) in administrative costs. The fee charged by the collection agency is merely a charge for providing the collection service; therefore, it is not treated as a bad debt.

Presumption of Non-collectability

If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.

This exhibit is designed to provide an example of collections attempts for written-off charges. The form is not a required form. Governmental Entities may utilize other internal data or reports to capture and show bad debt costs applicable to the cost report.

Column 1 – Procedure or Transaction ID (Identifier)

Enter the Process or Transaction identifier for service provided to patient.

Column 2 – Procedure Codes

Enter the applicable procedure codes for the services provided to the patient.

Column 3 – Procedure Descriptions

Enter the descriptions for the procedure codes used when services were provided to the patient.

Column 4 – Date of Service

Enter the date the service was provided.

Column 5 – Insurance Carrier Name

Enter the name of the patient’s insurance carrier. If no insurance, enter NA.

Column 6 – Medicaid Recipient Number

Enter the Medicaid/Medicaid Managed Care Recipient Number if the patient is covered by Medicaid or if the patient has coverage through a managed care organization. Leave this field blank or enter "NA" if the patient is insured by any other means.

Column 7 – Units

Enter the unit of service allowable for services provided to a client.

Column 8 – Charge Amounts

Total billed charges for services provided to the patient.

Column 9 – Paid Amount(s)

Amounts paid by patient/responsible party for services provided.

Column 10 – If Uninsured, Dates Billed/Notices Sent, Call made

Dates of attempted bill collections or notice sent to the patient/responsible party for services provided.

Column 11 – If Uninsured/Uncollectible, Write Off Date

Enter the date receivable was written off.

Column 12 – Total Uncompensated Costs

Enter the amount of uncompensated costs for the reporting periods of service.

Appendix A. Exhibit 2

Exhibit 2: Examples of Supplies, Materials, and Equipment

- Audiometer (calibrated annually), tympanometer
- Bandages, including adhesive (e.g., Band-Aids) and elastic, of various
- Battery testers, hearing aid stethoscopes, and earmold cleaning materials
- Blood Glucose Meter
- BMI Calculator
- Clinical audiometer with sound field capabilities
- Cold packs
- Cotton balls
- Cotton-tip applicators (swabs)
- Dental floss
- Diapers and other incontinence supplies
- Disinfectant
- Disposable gloves (latex-free)
- Disposable gowns
- Disposable Suction Unit
- Ear mold impression materials
- Electroacoustic hearing aid analyzer
- Electronic Suction Unit
- Evaluation tools (e.g., goniometers, dynamometers, cameras)
- Eye pads
- FM amplification systems or other assistive listening devices
- Gauze
- Immunization supplies and materials
- Loaner or demonstration hearing aids
- Medicine cabinet (with lock)
- Nebulizers
- Otoscope
- Otoscope/ophthalmoscope with battery
- Peak Flow Meters
- Physician's scale that has a height rod and is balanced
- Portable acoustic immittance meter
- Portable audiometer
- Reflex hammer
- Sanitary pads, individually wrapped (may be used for compression)
- Scales
- Scoliometer
- Slings
- Sound-level meter
- Sound-treated test booth
- Sphygmomanometer (calibrated annually) and appropriate cuff sizes
- Splints (assorted)
- Stethoscope
- Surgi-pads
- Syringes (Medication administration or bolus feeding)
- Test materials for central auditory processing assessment
- Tissues
- Tongue depressors
- Triangular bandage
- Vision testing machine, such as Titmus

PUBLIC HEALTH PROVIDER CHARITY CARE PROGRAM

COMMUNITY MENTAL HEALTH CENTERS AND LOCAL HEALTH DEPARTMENTS

Revised 06/25/2021

Complete Shaded Areas Only

COST REPORT FOR:	
Beginning of Reporting Period:	10-01-21
End of Reporting Period:	09-30-22
Primary 9-Digit Texas Provider Identification # (TPI):	555555555
Primary 10-Digit National Provider Identification # (NPI):	5555555555

Associated 9-Digit Texas Provider Identification # (TPI):	Associated 10-Digit National Provider Identification # (NPI):
555555555	5555555555
555555555	5555555555
555555555	5555555555
555555555	5555555555
555555555	5555555555
555555555	5555555555
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555555555	5555555555
555555555	5555555555

PROVIDER INFORMATION

Provider Name:	
Street Address:	
Mailing Address:	
Phone Number:	
FAX Number:	
Email:	

BUSINESS MANAGER / FINANCIAL DIRECTOR

Name:	
Title:	
Agency Name:	
Mailing Address:	
Phone Number:	
FAX Number:	
Email:	

REPORT PREPARER IDENTIFICATION

Name:	
Title:	
Agency/Business Name:	
Mailing Address:	
Phone Number:	
FAX Number:	
Email:	

LOCATION OF ACCOUNTING RECORDS THAT SUPPORT THIS REPORT

Physical Address:	

PUBLIC HEALTH PROVIDER CHARITY CARE PROGRAM COST REPORT

COST REPORT for

0

Primary 9-Digit TPI: 555555555

Primary 10-Digit NPI: 5555555555

Complete Shaded Areas Only

GENERAL AND STATISTICAL INFORMATION

	General Provider Information		**HHSC Adj.**
1.00	Reporting Period - Beginning	10-01-21	
1.01	Reporting Period - Ending	09-30-22	
1.02	Is Reporting Period less than a full year?	NO	
1.03	If Yes, provide a reason why.		
	Statistical Information		**HHSC Adj.**
1.04	Medicaid Fee for Service (FFS) Paid Claims Amount	$ - 0	$ - 0
1.05	Total Billed Charges Associated With Medicaid FFS Paid Claims	$ - 0	$ - 0
1.06	Medicaid Managed Care Organization (MCO) Paid Claims	$ - 0	$ - 0
1.07	Total Billed Charges Associated With MCO Paid Claims	$ - 0	$ - 0
1.08	Uninsured/Uncompensated Care Reimbursement	$ - 0	$ - 0
1.09	Uninsured/Uncompensated Care Charges	$ - 0	$ - 0
1.10	Grants/Donations/Appropriations Paid for Direct Medical Services	$ - 0	$ - 0
1.11	Billed Charges Associated with Grants/Donations/Appropriations Paid for Direct Medical Services	$ - 0	$ - 0
1.12	Total Allowable Costs for Reporting Period (Exhibit 2 - Direct Medical 2.24)	$ - 0	$ - 0
1.13	Total Paid Claims and Uninsured Reimbursement	$ - 0	$ - 0
1.14	Total Billed Charges for Reporting Period (FFS+MCO+Uninsured)	$ - 0	$ - 0
	Additional Statistical Information		
1.15	Medicare Charges	$ - 0	$ - 0
1.16	Self Pay, County/City Indigent Recipient Program Charges	$ - 0	$ - 0
1.17	Other Third-Party Insurance Coverage Charges	$ - 0	$ - 0

To be completed by HHSC Staff only.
Reviewed by:
Approved by:
Settlement Date:

PUBLIC HEALTH PROVIDER CHARITY CARE PROGRAM COST REPORT

COST REPORT for

0

Primary 9-Digit TPI: 555555555

Primary 10-Digit NPI: 5555555555

Complete Shaded Areas Only

SERVICES

PAYROLL EXPENSES		Amount
2.00	Employee Gross Salary (Enter on Exhibit 6 Schedule B)	$ - 0
2.01	Employee Benefits (Describe in External Support)	$ - 0
2.02	Employer Retirement Contribution	$ - 0
2.03	Employer FICA Payroll Taxes	$ - 0
2.04	Employer Other Payroll Taxes	$ - 0
2.05	State Unemployment Payroll Taxes	$ - 0
2.06	Federal Unemployment Payroll Taxes	$ - 0
2.07	Unemployment Compensation (Reimbursing Employer)	$ - 0
2.08	Total Staff Costs (sum items 2.00 thru 2.07)	$ - 0
OTHER COSTS		
2.09	Supplies & Materials:	
2.10	Supplies & Materials Non-Medical (Provide additional support)	$ - 0
2.11	Supplies & Materials Medical (Provide additional support)	$ - 0
2.12	Equipment:	
2.13	Equipment Non Medical (Provide additional support)	$ - 0
2.14	Equipment Medical (Provide additional support)	$ - 0
2.15	Support Services (IT, Dispatch, Call Handling, etc.)	$ - 0
2.16	Other Costs (Provide additional support for all other costs)	$ - 0
2.17	Depreciation (Exhibit 5 Schedule A)	$ - 0
2.18	Total Direct Other Costs (sum items 2.09 through 2.17)	$ - 0
2.19	Medical Clients Served	- 0
2.20	All Clients Served (Medical + Non-Medical)	- 0
2.21	Allocation Ratio (2.19 divided by 2.20)	0.00%
2.22	Total Direct Medical Other Costs	$ - 0
2.23	TOTAL Staff and Direct Medical Other Costs (sum items 2.08 and 2.22)	$ - 0
REDUCTIONS:		
2.24	Other Federal Funds and Grants/Donations/Appropriations (Exhibit 1 and Exhibit 6 Schedule B)	$ - 0
2.25	Other (Describe in External Support)	$ - 0
2.26	TOTAL Reductions (sum items 2.24 and 2.25)	$ - 0

COST SETTLEMENT CALCULATION:			HHSC Review
2.27	Total Billed Charges For Period of Service	$ - 0	$ - 0
2.28	Total Allowable Costs for Period of Service	$ - 0	**- 0**
2.29	Cost to Charge Ratio	0.00%	0.00%
2.30	Total Billed Charges Associated with Medicaid and Uninsured Cost Claims	$ - 0	$ - 0
2.31	Medicaid and Uninsured Cost	$ - 0	$ - 0
2.32	Minus Medicaid Payments, Uninsured Fees Collected, and Reductions	$ - 0	$ - 0
2.33	Equals Settlement Amount	$ - 0	$ - 0
2.34	Multiplied by FMAP for appropriate fiscal year	60.80%	60.80%
2.35	**Equals Amount due to Provider (Before Proportionate Reduction)**	$ - 0	$ - 0

PUBLIC HEALTH PROVIDER CHARITY CARE PROGRAM COST REPORT

COST REPORT for

0

Primary 9-Digit TPI: 555555555

Primary 10-Digit NPI: 5555555555

Complete Shaded Areas Only

Cost Report Certification

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

- **The cost report will include only allocable expenditures related to Medicaid FFS, Medicaid Managed Care and the Uninsured (Uncompensated Care) as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program.**
- **I have read the note below, the cover letter and all the instructions applicable to this cost report.**
- **I have reviewed this entire cost report after its preparation.**
- **To the best of my knowledge and belief, this cost report is true, correct and complete, and was prepared in accordance with all the instructions applicable to this cost report.**
- **I certify that the provider meets the definition of a Qualifying Provider per Title 1 Texas Administrative Code Section 355.8215(b)(6) and is a unit of government able to certify expenditures to participate in the program. I certify that all expenses are allocable to the unit of government and not to any entity with a 501(c)(3) designation.**
- **This cost report was prepared from the books and records of the Public Health Provider -- Charity Care Program provider.**
- **The expenditures on this cost report have not been claimed on any other cost report.**
- **I certify that no part of any PHP-CCP payment will be used to pay a contingent fee and that any agreement between the provider and a billing entity or cost report preparer does not use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program, including PHP-CCP funds.**
- **I understand that this information will be used as a basis for claims for Federal funds, and possibly State funds, and that falsification and concealment of a material fact may be prosecuted under Federal and State civil or criminal law.**

NOTE: This COST REPORT CERTIFICATION must be signed by an individual legally responsible for the authorized agent, i.e., PHP-CCP representative, such as Chief Financial Officer or other official of the Governmental Entity. Misrepresentation or falsification of any information contained in this report may be punishable by fine and/or imprisonment under federal and/or state law.

SIGNER IDENTIFICATION

Printed/Typed Name of Report Preparer/Contracted Vendor	Title of Preparer/Contracted Vendor	Vendor Company Name (if applicable)

Printed/Typed Name of Authorized Signatory	Title of Signer

Name of Provider:

Address of Signer (street or P.O. Box, city, state, 9-digit zip):

Phone Number (including area code)	FAX Number (including area code)	Email:
555555-5555		

SIGNATURE OF SIGNER

DATE

SIGNER AUTHORITY: CFO

Other Officer (describe)

(check one) Business Officer

Director

Subscribed and sworn before me, _____ , a notary public on _____

Notary Name

month / day / year

NOTARY SIGNATURE

NOTARY PUBLIC, STATE OF

COMMISSION EXPIRES

NOTARY SEAL

PUBLIC HEALTH PROVIDER CHARITY CARE PROGRAM COST REPORT

COST REPORT for
0

Primary 9-Digit TPI: 555555555
Primary 10-Digit NPI: 5555555555

Complete Shaded Areas Only

Certification Of Funds

This statement is of expenditures that the undersigned certifies are allocable and allowable to the State Medicaid program under Title XIX of the Social Security Act (the Act), and in accordance with all procedures, instructions and guidance issued by the single state agency and in effect during the cost report federal fiscal year.

Total Computable Expenses

Expenditures submitted to the Texas HHSC for FFY _____ Medicaid/Medical Services $ **0**

HHSC Review
- 0

Potential Settlement Amount

$ **0**

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED HEREIN MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.

CERTIFICATION STATEMENT BY OFFICER OF THE PROVIDER

I HEREBY CERTIFY that for the reporting period: From: **10-01-21** To: **09-30-22**

1. I have examined this statement, the accompanying supporting exhibits, the allocation of expenses and services, and the worksheets for the above indicated reporting period and to the best of my knowledge and belief they are true and correct statements prepared from the books and records of the Provider in accordance with applicable instructions.
2. The expenditures included in this statement are based on the actual cost of recorded expenditures.
3. The required amount of state and/or local funds were available and used to pay for total computable allowable expenditures included in this statement, and such state and/or local funds were in accordance with all applicable federal requirements for the non-federal share match of expenditures, including, but not limited to, the requirement that the funds were not Federal funds in origin (unless they are Federal funds authorized by Federal law to be used to match other Federal funds) and the requirement that the claimed expenditures were not used to meet matching requirements under other Federally funded programs.
4. The expenditures on this cost report have not been claimed on any other cost report.
5. I understand that this information will be used as a basis for claims for Federal funds, and possibly State funds, and that falsification and concealment of a material fact may be prosecuted under Federal and State civil or criminal law.
6. Federal matching funds are being claimed on this report in accordance with the cost report instructions provided by the Texas Health and Human Services Commission effective for the above indicated reporting period.
7. I am the officer authorized by the referenced government agency to submit this form and I have made a good faith effort to ensure that all Texas Health and Human Services Commission effective for the above indicated reporting period information reported is true and accurate.
8. I understand that this information will be used as a basis for claims for Federal funds, and possibly State funds, and that falsification and concealment of a material fact may be prosecuted under Federal or State civil or criminal law.

SIGNATURE | DATE

Printed/Typed Name of Signer | Title of Signer

Address of Signer (street or P.O. Box, city, state, 9-digit zip)

Phone Number (including area code) | FAX Number (including area code) | Email

SIGNER AUTHORITY: _____ CFO _____ Business Officer _____ Director

(check one) _____ Other Agent/Representative (describe)

Subscribed and sworn before me, _____, a notary public on _____
Notary Name | month / day / year

_____ | _____ | _____
Notary Signature | Notary Public, State Of | Commission Expires

_____
NOTARY SEAL

PUBLIC HEALTH PROVIDER CHARITY CARE PROGRAM COST REPORT

COST REPORT for

0

Primary 9-Digit TPI: 555555555

Primary 10-Digit NPI: 5555555555

Complete Shaded Areas Only

Beginning of Reporting Period:	**10-01-21**
End of Reporting Period:	**09-30-22**

SCHEDULE A
DEPRECIATION -- PUBLIC HEALTH PROVIDER CHARITY CARE PROGRAM -- (Straight-Line Method Only)

A	B	C	D	E	F	G	H	I	K	L	M	N	O	P	Q
Description of Asset	Month/Day/Year Placed in Service	Years of Useful Life	Cost	Salvage Value	Prior Period Accumulated Depreciation	When Asset Will Meet End of Useful Life	Asset Disposed of in FFY? (Y/N)	Month/Day/Year of Disposal (if Y in Column H)	Useful Life Begins This Period	Beginning Date	Months of Useful Life	Useful Life Ends in This Period	Ending Date	Months of Depreciation	HHSC Allowable Depreciation For Reporting Period
BUILDINGS:															$ - 0
				$ - 0		12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
				$ - 0		12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
				$ - 0		12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
				$ - 0		12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
				$ - 0		12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
				$ - 0		12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
				$ - 0		12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
				$ - 0		12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
				$ - 0		12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
				$ - 0		12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
				$ - 0		12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
				$ - 0		12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
				$ - 0		12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
				$ - 0		12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
				$ - 0		12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
														TOTAL	$ - 0
VEHICLES:															
						12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
						12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
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						12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
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EQUIPMENT:															
						12-30-99			N	10-01-21	0	N	09-30-22	12	$ - 0
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Total Services Depreciation															$ - 0

PUBLIC HEALTH PROVIDER CHARITY CARE PROGRAM COST REPORT

COST REPORT for

0

Primary 9-Digit TPI: 555555555

Primary 10-Digit NPI: 5555555555

Complete Shaded Areas Only

SCHEDULE B
PAYROLL AND BENEFITS

EMPLOYEE INFORMATION					PAYROLL AND BENEFITS										FED FUNDING REDUCTION			
Employee # (NO personal identifiers i.e. SSN)	Last Name	First Name	Job Title / Credentials	(E)mployee or (C)ontracted	Gross Salary	Total Hours Worked	Contractor Payments	Employee Benefits	Employer Retirement Contribution	Employer - FICA Payroll Taxes	Employer - Other Payroll Taxes	State Unemployment Payroll Taxes	Federal Unemployment Payroll Taxes	Unemployment Compensation (Reimbursing Employer)	Position Fully or Partially Funded By Fed Funds or Grants? Yes or No	If Yes, Amount of Federal Funding	Other Amounts To Be Removed	Total Reduction
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TOTAL BENEFITS AND REDUCTIONS					$ - 0	- 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0

PUBLIC HEALTH PROVIDER CHARITY CARE PROGRAM COST REPORT

COST REPORT for	
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Primary 9-Digit TPI:	555555555
Primary 10-Digit NPI:	5555555555

Complete Shaded Areas Only

Cost Allocation Methodologies Employed by the Governmental Entity

A. Does your agency have a Cost Allocation Plan (CAP)? If so, please provide a copy of your agency's proposed Cost Allocation Plan (CAP). If not, enter in detail the allocation methodology that will be used for allocating costs on the cost report.

B. Please provide a list of personnel cost worksheets that support your CAP. Attach Detailed Explanation Externally .

PUBLIC HEALTH PROVIDER CHARITY CARE PROGRAM COST REPORT

COST REPORT for

0

Primary 9-Digit TPI: 555555555

Primary 10-Digit NPI: 5555555555

Complete Shaded Areas Only

EXAMPLE ONLY

Exhibit 8 - Schedule D Reasonable Collections Effort Tracking Form

(1) Procedure/Trans ID (Identifier)	(2) Procedure Codes Submitted	(3) Procedure Description	(4) Date of Service - DOS	(5) Insurance Carrier Name	(6) If Medicaid/Medicaid Managed Care - Recipient Number	(7) Units	(8) Charge Amount(s)	(9) Paid Amount(s)	(10) If Uninsured, Billed/Notice Dates Sent to Patient	(11) If Uninsured and Uncollectible Write Off Date	(12) Total Uncompensated Costs (12) = (8) - (9)
12345	AXXXX	Example Procedure 1	10-01-12	Uninsured	NA	1.000	$ 840.00	$ 15.00	01-15-13 02-15-13 03-15-13	NA NA 04-15-13	$ 825.00
78945	AXXX1	Example Procedure 2	11-12-12	Superior	W23456	1	$ 435.10	$ 435.10	NA	NA	$ - 0
25687	AXXX2	Example Procedure 3	11-15-12	Uninsured	NA	20	$ 138.80	$ 90.00	12-15-12 01-15-13	NA	$ - 0
10425	AXXX3	Example Procedure 4	12-01-12	Superior	W23789	25	$ 525.65	$ 117.75			
Total All							$ 1,099.55	$ 642.85			$ 825.00

Column 1 - Proc/Trans ID (Identifier)	Enter the Process /Transaction identifier for service provided to patient.
Column 2 - Procedure Codes	Enter the applicable procedure codes for the services provided to the patient.
Column 3 - Procedure Descriptions	Enter the descriptions for the procedure codes used when service was provided to the patient.
Column 4 - Date of Service	Enter the date service was provided.
Column 5 - Insurance Carrier Name	Enter the name of the patients insurance carrier.
Column 6 - Medicaid Recipient Number	Enter the Medicaid/Medicaid Managed Care Recipient Number if the patient is covered by Medicaid or if the patient has a coverage through a managed
Column 7 - Units of Service	Enter the unit of service allowable for services provided to a client.
Column 8 - Charge Amounts	Total billed charges for services provided to patient.
Column 9 - Paid Amount(s)	Amounts paid by patient/responsible party for services provided.
Column 10 - If Uninsured, Dates Billed/Notices Sent, Call made	Dates of attempted bill collections or notice sent to patient/responsible party for services provided.
Column 11 - If Uninsured/Uncollectible, Write Off Date	Enter the date receivable was written off.
Column 12 - Total Uncompensated Costs	Enter the amount of uncompensated costs for the reporting periods of service.

REASONABLE COLLECTION EFFORT

To be considered a reasonable collection effort, a provider's effort to collect fees for services rendered must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment.

Collection Agencies. --A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, it is expected that the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.

Documentation Required. --The provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.

Collection Fees.--Where a provider utilizes the services of a third party, non-related collection agency and the reasonable collection effort is applied, the fees the collection agency charges the provider are recognized as an allowable administrative cost of the provider.

When a collection agency obtains payment of an account receivable, the full amount collected must be credited to the patient's account and the collection fee charged to administrative costs. For example, where an agency collects $40 from the patient/responsible party, and its fee is 50 percent, the agency keeps $20 as its fee for the collection services and remits $20 (the balance) to the provider. The provider records the full amount collected from the patient by the agency ($40) in the patient's account receivable and records the collection fee ($20) in administrative costs. The fee charged by the collection agency is merely a charge for providing the collection service, and, therefore, is not treated as a bad debt.

Presumption of Noncollectibility.--If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.