TEXAS NURSING FACILITY
ENHANCED DIRECT CARE STAFF RATE

FISCAL YEAR 2014
REQUEST FOR REVISION REPORT
INSTRUCTIONS

For assistance with the completion of these forms, contact Rate Enhancement Analyst for this program listed on the following webpage: http://www.hhsc.state.tx.us/rad/long-term-svcs/contacts.shtml.

For assistance with the mailing and tracking of this report, contact:

Cost Reporting Specialist
Phone: (512) 707-6094
FAX: (512) 730-7475

PURPOSE

The purpose of the Request for Revision Report (RFR) is to gather information for the Texas Health and Human Services Commission (HHSC) to use in determining if a facility met a higher staffing level for the reporting period than the level it met on its most recently available, audited report functioning as its fiscal year 2011 Staffing and Compensation Report.

WHO MUST COMPLETE THIS REPORT?

All facilities requesting a revision of their enrollment limitation for the fiscal year 2014 enhancement period (September 1, 2013 – August 31, 2014) must complete this report.

GENERAL INSTRUCTIONS

Except where otherwise noted, this Request for Revision Report is governed by all rules and instructions pertaining to the completion of your Texas Nursing Facility Cost Report. Refer to:

- Cost Determination Process rules at Title 1 of the Texas Administrative Code (TAC) §§355.101-355.110;
- Direct Care Staff Rate Component rules at 1 TAC §355.308;
- Nursing Facility (NF) program-specific rules at 1 TAC §355.307;
- Mandatory Training for the 2011 or 2012 Cost Reports; and
- Specific Instructions for the completion of the 2011 or 2012 NF Cost Report.

DUE DATE

This report is due to HHSC by **July 31, 2013**. Send one completed copy of the Request for Revision Report and all required attachments, including the certification and methodology pages with original signatures and notary stamps/seals, to:

REGULAR MAIL:
HHSC Rate Analysis
Mail Code H-400
P.O. Box 149030
Austin, TX 78714-9030

SPECIAL DELIVERY:
HHSC Rate Analysis
Brown Heatly Building
Mail Code H-400
4900 North Lamar
Austin, TX 78751-2399

Reports received after July 31, 2013 will not be accepted and the enrollment limitation specified on the provider's fiscal year 2014 "Enrollment Limitation Report" will apply.

WEBSITE

An electronic version of the 2014 Request for Revision Report is available on our website at:

http://www.hhsc.state.tx.us/rad/long-term-svcs/nursing-facility/index.shtml

Once you access the website, scroll down to the heading "Rate Enhancement – Direct Care Staff Compensation", click on "2014 Rate Enhancement – Direct Care Staff Compensation Information". Under the heading "2014 Enrollment Limitations Information", locate and open the "2014 Request for Revision Report".

REPORTING PERIOD

The reporting period is September 1, 2012 through April 30, 2013. The report must be completed for the entire reporting period.

If your facility underwent a change of ownership where the Texas Department of Aging and Disability Services (DADS) approved a successor-liability-agreement (SLA) that transferred responsibility from the former owner to the new owner, this report may include units of service, staff hours and expenses from both the contract in effect prior to the initiation of the SLA and the contract in effect after the initiation of the SLA.

ROUNDING

All reported monetary amounts should be rounded to the nearest whole number (with no zeros included for "cents"). For example, $25.49 should be rounded to $25 while $25.50 should be rounded to $26. All reported times should be rounded to the nearest hour. For example, 2 hours and 15 minutes should be rounded to 2 hours while 2 hours and 45 minutes should be rounded to 3 hours. Reports submitted without proper rounding of monetary amounts and times may be returned for proper completion.

ACCOUNTING METHOD

All information submitted on the report must be based on an accrual method of accounting, see 1 TAC §355.105(b)(1), except where otherwise specified. Governmental entities may report on a cash basis or modified accrual basis.

COST ALLOCATION

Refer to the Cost Determination Process rules at 1 TAC §355.102(j) and §355.105(b)(2)(B)(v) for information concerning allowable allocation methods and requirements for adequate allocation summaries. Note that costs must be directly costed whenever reasonably possible. FICA/Medicare, unemployment, worker's compensation premiums and paid claims and employee health paid claims may be allocated to direct care staff based on salaries or direct costed. Health insurance premiums, life insurance premiums and other employee benefits must be direct costed.

All staff times, salaries, wages and contract labor costs reported on page 3 the Request for Revision Report must be directly charged according to payroll records and timesheets. The only exception to this requirement is when nursing personnel work for both Medicaid-contracted and noncontracted NF beds. In such a situation, the hours worked and related costs must be allocated between contracted and noncontracted beds based upon units of service (i.e., resident days) and an acceptable allocation summary must be attached. See the definition of "Direct Care" for a further discussion of cost allocation.

REPORT CERTIFICATION

Contracted providers must certify the accuracy of the Request for Revision Report submitted to HHSC. Contracted providers may be liable for civil penalties, criminal penalties and/or imprisonment if the Request for Revision Report is not completed according to HHSC requirements or if the information is misrepresented and/or falsified. Before signing the certification pages, carefully read the certification statements to ensure that the signers have complied with the reporting requirements. The Methodology Certification advises preparers that they may lose the authority to prepare future reports if reports are not prepared in accordance with all applicable rules, instructions and mandatory training materials. **NOTE:** any report submitted without original signed and notarized Certification and Methodology Certification pages will be returned to the provider. Copies and faxes will not be accepted.

DEFINITIONS

Accrual Accounting Method - method of accounting in which revenues are recorded in the period in which they are earned and expenses are recorded in the period in which they are incurred. If a provider operates on a cash basis, it will be necessary to convert from cash to accrual basis for reporting purposes. Care must be taken to ensure that a proper cutoff of accounts receivable and accounts payable occurred both at the beginning and ending of the reporting period. Amounts earned although not actually received and amounts owed to employees and creditors but not paid should be included in the reporting period in which they were earned or incurred. Allowable expenses properly accrued during the reporting period must be paid within 180 days after the end of the reporting period in order to remain allowable costs for reporting purposes. If accrued expenses are not paid within 180 days after the end of the reporting period, the expense is unallowable and should not be reported on the report

Contract Labor – labor provided by nonstaff Registered Nurses (RNs), including Directors of Nursing (DONs) and Assistant Directors of Nursing (ADONs), Licensed Vocational Nurses (LVNs), including DONs and ADONs, Medication Aides and Certified Nurse Aides (CNAs), including Restorative Aides, performing nursing-related duties for Medicaid contracted beds. Nonstaff refers to personnel who provide services to the facility intermittently, whose remuneration (i.e., fee or compensation) is not subject to employer payroll tax contributions and who perform tasks routinely performed by

employees. Contract labor hours do not include consultant hours. Contract labor hours must be associated with allowable contract labor costs as defined in 1 TAC §355.103(b)(2)(C).

Contracted Provider - the business component with which DADS contracts for the provision of NF services.

Controlling Entity - the individual or organization that owns the contracting entity.

Direct Care – resident care provided by nursing personnel (i.e., Registered Nurses (RNs), including Directors of Nursing (DONs) and Assistant Directors of Nursing (ADONs), Licensed Vocational Nurses (LVNs), including DONs and ADONs, Medication Aides and Certified Nurse Aides (CNAs), including Restorative Aides, in order to carry out the physician's planned regimen of total resident care. To be allowable as direct care staff on this report, an individual must both meet the appropriate professional certification or licensure requirements <u>and</u> perform nursing-related duties for Medicaid-contracted beds. The actual time (i.e., directly charged time) spent working in one of these positions for the nursing facility must be reported.

Nursing personnel who work performing both nursing facility direct care functions and other functions (e.g., nursing facility administrative functions or any functions for other business components such as a retirement center, residential care center, assisted living component, etc.) must maintain continuous daily timesheets. The daily timesheet must document, for each day, the person's start time, stop time, total hours worked, and the actual time worked (in increments of 30 minutes) performing nursing facility direct care functions and the actual time worked performing other functions. Time must be directly charged and allocation of time is not acceptable in such situations.

The only exception to the "no allocation rule" is when nursing personnel work for both Medicaid-contracted and noncontracted licensed nursing facility beds. In such a situation, if the hours and costs cannot be reasonably direct costed in accordance with the Centers for Medicare and Medicaid Services (CMS) requirements for distinct reporting, the hours worked and associated costs must be allocated between contracted and noncontracted beds based upon units of service (i.e., resident days) and an acceptable allocation summary must be attached.

Staff members who perform more than one function in a <u>facility without a differential in pay between functions</u> are to be categorized at the highest level of licensure or certification they possess. If this highest level of licensure or certification is not that of an RN, LVN, Medication Aide, or CNA, the staff member is not to be included in the direct care staff cost center. The only exceptions to this rule are respiratory therapists in facilities receiving the ventilator and/ or pediatric tracheotomy supplemental payments (see "Common Questions/Issues" #10). Administrators and assistant administrators are not direct care staff and should not be included on this report.

Required documentation of direct care staff hours and compensation includes, but is not limited to, proof of licensure and certification status, time sheets (for staff performing more than one function or working for more than one entity), job descriptions, and payroll records.

Common Questions/Issues Regarding the Proper Reporting of Direct Care Staff

1. The following functions are considered direct care functions if performed by a Director of Nursing (DON), Assistant Director of Nursing (ADON), RN, LVN, Medication Aide or CNA: completion of the MDS assessment forms; development of care plans; attendance at in-service training; and the nursing administration aspects of a DON or ADON's job including the provision of classroom-based in-service training.

2. The following functions are not considered direct care functions: paid feeding assistants, medical records; central supply; someone other than the DON or ADON presenting classroom-based in-service training; quality assurance nursing consultant from central office; transcribing physicians orders; and time spent filling water pitchers and changing linen by individuals other than RNs, LVNs, Medication Aides and CNAs.

3. Does paid time off for direct care staff (e.g., paid vacation, paid sick leave) count as direct care time for this report? Yes, but if it is associated with an individual performing more than one function, it needs to be allocated. If a staff person "cashes in" his/her paid time off instead of taking leave, the time associated with this leave is not to be reported on this report. The compensation received as a result of "cashing in" is treated as a bonus and should be reported in the period in which it is subject to payroll taxes.

4. Pay for being "on-call" is reported as salaries by employee type but only on-call hours actually worked performing direct care functions can be reported as time. For example, if an RN was on call for an entire weekend and received $200 as on-call compensation, the total $200 would be reported as salaries. If the RN was required for 3 hours to provide assistance to staff while on-call during the weekend, only 3 hours would be reported as paid hours and not the full 48 hours of the weekend.

5. Graduate Vocational Nurses (GVNs) should be reported as LVNs.

6. Unpaid overtime hours that meet all the other requirements to be reported as direct care staff time may be reported if they are properly documented. Unpaid overtime hours should be reported at the highest level of licensure or certification the individual working the overtime possesses. For example, if an RN DON works four hours unpaid overtime after the end of her shift, filling in for an absent Medication Aide, the four hours should be reported as RN time. Since the overtime is unpaid, no associated compensation should be reported.

Compensation costs may not be imputed for unpaid overtime hours. Volunteer time should not be included on this report.

7. Paid overtime that meets all the other requirements to be reported as direct care staff time may be reported if it is properly documented. Paid overtime hours and compensation should be reported at the highest level of licensure or certification the individual working the overtime possesses. For example, if an RN DON works four hours paid overtime after the end of her shift, filling in for an absent Medication Aide, the four hours and associated compensation should be reported as RN hours and compensation.

8. Nurses that are also schedulers, facility-based quality assurance nurses and CNAs that drive vans must spend at least 50% of their time on direct care functions in order to report 100% of their paid hours and salaries as direct care. To document the 50+%, the employee should perform a one-month functional study (i.e., maintain daily timesheets for an entire month). Such a functional study should be completed at least annually. Otherwise, they must maintain daily, continuous timesheets to directly charge as direct care only those hours/salaries applicable to direct care functions. Time spent driving a van is not considered direct care time.

9. A nurse whose job function is charting is considered to be providing direct care.

10. Respiratory therapists providing direct care in facilities receiving the ventilator and/or pediatric tracheotomy supplemental payments may be counted as LVNs.

11. Nurse aides in the Nurse Aide Training and Competency Evaluation Program (NATCEP) can only be included on this report if they have completed at least the first 16 hours of NATCEP training. Any time worked before 16 hours of NATCEP training are completed may not be included on this report (e.g., time spent as a hospitality aide or receiving the first 16 hours of training).

12. Quality assurance nurse consultants from the central office are not considered direct care staff.

13. Physical, occupational and speech therapists, activities staff and social work staff are not direct care staff.

14. Staff members performing more than one function in a facility without a differential in pay between functions are categorized at the highest level of licensure or certification they possess. If this highest level of licensure or certification is not that of an RN, LVN, Medication Aide, or CNA, the staff member is not to be included in the direct care staff cost center but rather in the cost center where staff members with that licensure or certification status are typically reported.

15. Nursing facility administrators and assistant administrators are not included in the direct care cost center.

16. Time spent working on a non-contracted wing is not direct care time.

Medicaid-Contracted Beds – licensed nursing beds contracted with DADS to provide nursing facility services to Medicaid residents. These contracted beds can be occupied by Medicaid residents, Medicare residents (if the beds are dually certified) and Other residents (e.g., private pay, private insurance, V.A., etc.).

Related Party - a person or organization related to the contracted provider by blood/marriage, common ownership, or any association, which permits either entity to exert power or influence, either directly or indirectly, over the other. In determining whether a related-party relationship exists with the contracted provider, the tests of common ownership and control are applied separately. Control exists where an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related 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 reporting purposes: (1) husband and wife; (2) natural parent, child and sibling; (3) adopted child and adoptive parent; (4) stepparent, stepchild, stepsister, and stepbrother; (5) father-in-law, mother-in-law, brother-in-law, son-in-law, sister-in-law, and daughter-in-law; (6) grandparent and grandchild; (7) uncles and aunts by blood or marriage; (8) first cousins, and (9) nephews and nieces by blood or marriage. Disclosure of related-party information is required for all allowable costs reported by the contracted provider.

COVER PAGE

9-DIGIT NF CONTRACT #

Enter your current 9-digit NF contract number. If, after looking at the upper right-hand corner of your most recent nursing facility cost report, your recent payment information, correspondence from DADS, and/or your contract with DADS, you do not know your correct 9-digit nursing facility contract number, please contact the Rate Analyst listed on the cover of these instructions. Be sure to enter your 9-digit NF contract number in the block provided in the top right-hand corner of each page of the Request for Revision Report.

FACILITY IDENTIFICATION

Enter the trade name or doing-business-as (dba) name and all requested information for the provider facility.

CONTRACTING ENTITY
Enter the requested information regarding the business entity that contracts with DADS to provide NF services to Medicaid residents in the facility identified in FACILITY IDENTIFICATION above.

CONTACT
The contact person is the employee of the provider who is designated to be contacted concerning information reported on the Request for Revision Report. The contact person should be able to answer questions about the contents of the report that arise during the HHSC Rate Analysis Department's edit process and the HHSC Office of Inspector General's audit verification process.

PREPARER
The preparer of the Request for Revision Report is the person who actually prepared the report, whether the preparer is an employee of the provider, contracting entity, etc. or is contracted to complete the report. For this reporting period, the preparer must have attended the required nursing facility cost report training as per 1 TAC §355.102(d) (relating to General Principles of Allowable and Unallowable Costs) for completing the 2011 or 2012 Nursing Facility cost report. If the preparer and contact are the same person, you may enter "See contact".

RECORDS LOCATION:
Report the address where the provider's accounting records and supporting documentation used to prepare this Request for Revision Report are maintained. This should be the address at which a field audit of these records can be conducted.

NUMBERED REPORT ITEMS

ITEM 1 (Current DADS NF 9-digit Contract Number)
Enter your current 9-digit NF contract number from the cover page of this report.

ITEM 2 (9-digit Contract Number Prior to Any Successor Liability Agreement)
If this report includes units of service, staff hours and expenses from a contract in effect prior to the initiation of an SLA with DADS, enter the 9-digit NF contract number for the contract in effect prior to the initiation of the SLA.

ITEM 3 (DADS NF 4-digit Provider Number)
Enter the 4-digit DADS NF facility number. If you completed a 2012 NF cost report, the 4-digit DADS NF facility number is the number entered in Item 2 of that report.

ITEM 4 (Texas County Code in Which Accounting Records are Located)
Report the 3-digit county code for the Texas County in which the accounting records and supporting documentation used to prepare this report are located. If the accounting records are located outside the state of Texas, enter "999". The response to item 4 should

correspond to the information reported on the Cover page under the "Records Location" heading. Texas county codes are listed on the last page of these instructions.

ITEM 5 (Reporting Period - Beginning Date)
The reporting period beginning date must be September 1, 2012. If your facility has undergone a change of ownership where DADS has approved an SLA that transfers responsibility from the former owner to the new owner, this report may include units of service, staff hours and expenses from both the contract in effect prior to the initiation of the SLA and the contract in effect after the initiation of the SLA.

ITEM 6 (Reporting Period - Ending Date)
The reporting period ending date must be April 30, 2013. If your facility has undergone a change of ownership where DADS has approved SLA that transfers responsibility from the former owner to the new owner, this report may include units of service, staff hours and expenses from both the contract in effect prior to the initiation of the SLA and the contract in effect after the initiation of the SLA.

ITEM 7 (Were any owner-employees or other related-party employees included on this report?)
Check either "No" or "Yes". If "Yes", complete Schedule C for each owner-employee or other related-party employee and attach an organization chart that clearly indicates each owner-employee's and each related-party employee's position within the entire related organization. Refer to the DEFINITIONS section for a definition of a related-party.

ITEM 8 (Were any contracted services included on this report provided by a related organization?)
Check either "No" or "Yes". If "Yes", complete Schedule B, Section 1A. Refer to the DEFINITIONS section for a definition of a related-party.

ITEM 9 (Were any of the contracted services included on this report provided by a related individual?)
Check either "No" or "Yes". If "Yes", complete Schedule B, Section 1B. Refer to the DEFINITIONS section for a definition of a related-party.

ITEM 10 (Number of LICENSED NURSING beds)
Enter the number of nursing beds your facility had licensed for resident care by DADS at the end of its reporting period. Do not include facility beds licensed for non-nursing (i.e., personal care or hospital) care. Do not include unlicensed beds. Item 10 cannot be less than item 12.

ITEM 11 (Were the beds reported in item 10 licensed for the entire reporting period? If No, complete Schedule I)
Indicate whether or not the beds reported in item 10 were licensed for the entire reporting period. If "No", complete Schedule I.

ITEM 12 (Number of LICENSED NURSING beds CONTRACTED for Medicaid nursing care by DADS at the end of your reporting period)

Enter the number of beds your facility had contracted for nursing care with the Texas Medicaid program at the end of your reporting period. This number can be less than but not greater than the number of total licensed beds for nursing care.

ITEM 13 (Were the beds reported in item 12 contracted for the entire reporting period? If No, complete Schedule I)
Indicate whether or not the beds reported in item 12 were contracted for the entire reporting period. If "No", complete Schedule I.

ITEM 14 (Have you excluded all time worked before 16 hours of a Nurse Aide Training and Competency Evaluation Program are completed?)
The only nurse aides to be included on this report are Certified Nurse Aides and nurse aides in training who have completed at least the first 16 hours of a Nurse Aide Training and Competency Evaluation Program (NATCEP). Indicate whether you have excluded all time worked before 16 hours of NATCEP training are completed as well as associated salaries and wages from this report

ITEM 15 (Does this facility provide an in-house NATCEP?)
Indicate whether this facility provides an in-house NATCEP.

ITEM 16 (List ALL Texas Medicaid Nursing Facility Contracts)
Enter the total number of nursing facility contracts the contracting entity holds with the state of Texas, including the nursing facility for which this report is being completed in Item 16 and enter the 9-digit Nursing Facility contract number for each contract, including the nursing facility for which this report is being completed, on the lines below the item. List all the Texas Medicaid nursing facility contracts owned by the contracting entity, by any of its controlling entities, by its parent company/sole member, or owned/managed by its related-party management company (i.e., the entire related organization). If necessary, attach (and properly cross-reference) an attachment that provides the requested information. List both contracts participating in the direct care staff enhancement and contracts not participating.

ITEM 17 (Mandatory cost report training certificates)
Attach a copy of a state-conducted mandatory 2011 or 2012 NF cost report classroom training certificate or online training completion certificate for your preparer. Reports submitted without proper classroom or online training completion certificates attached are not considered acceptable reports, will not be processed until the required certificates have been received, and may be returned for proper completion if the required certificates are not received in a timely manner

ITEMS 18 – 99 (Reserved for future use)
Items 18 through 99 are reserved for future use.

DIRECT CARE HOURS AND COMPENSATION

See DEFINITION of "Direct Care" of these instructions before completing this page

ITEM 100 (Were any expenses reported on this page the result of the allocation of expenses?)
If any expenses on this page resulted from allocation, check "Yes". For each allocation method used, attach (and properly cross-reference to each applicable item): a detailed allocation summary showing 100% of your expenses by cost category, the numerator and denominator of the allocation calculation in words and numbers, the resulting allocation percentage (with 2 decimal places), the application of the allocation percentage to each shared cost, the amount allocated to each contract/program/business entity, and the report item on which each allocated cost is reported on this report. All direct care staff hours and salaries and wages must be directly charged according to payroll records and timesheets. The only exception to the "no allocation rule" is when nursing personnel work for both Medicaid-contracted and noncontracted licensed nursing facility beds. In such a situation, the hours worked and related compensation must be either directly charged or allocated between contracted and noncontracted beds based upon units of service (i.e., resident days).

ITEMS 101, 103, 105 and 107 (Employee Hours)
Report employee hours worked by Registered Nurses (RNs), including Directors of Nursing (DONs) and Assistant Directors of Nursing (ADONs), Licensed Vocational Nurses (LVNs), including DONs and ADONs, Medication Aides and Certified Nurse Aides (CNAs), including Restorative Aides, providing direct care services to residents in Medicaid-contracted beds during your reporting period in the appropriate item (i.e., 101, 103, 105 or 107). Hours worked include paid time off such as paid vacation time, paid sick time and paid all-purpose time. Round all reported hours to the nearest whole hour.

ITEMS 102, 104, 106 and 108 (Employee Salaries and Wages)
Report accrued direct care staff salaries and wages for Registered Nurses (RNs), including Directors of Nursing (DONs) and Assistant Directors of Nursing (ADONs), Licensed Vocational Nurses (LVNs), including DONs and ADONs, Medication Aides and Certified Nurse Aides (CNAs), including Restorative Aides, providing direct care services to residents in Medicaid-contracted beds during your reporting period in the appropriate item (i.e., 102, 104, 106 or 108). Salaries and wages include overtime, bonuses, and taxable fringe benefits. Round all reported monetary amounts to the nearest whole dollar. If reporting accrued/taken vacation and/or accrued/taken sick leave not yet subject to payroll taxes, these expenses must be reported as "Other Employee Benefits" in Item 124.

ITEMS 109, 111, 113 and 115 (Contract Labor Hours)
Report contract labor hours worked by nonstaff Registered Nurses (RNs), including Directors of Nursing (DONs) and Assistant Directors of Nursing (ADONs), Licensed Vocational Nurses (LVNs), including DONs and ADONs, Medication Aides and Certified Nurse Aides (CNAs), including Restorative Aides, providing direct care services to residents in Medicaid-contracted beds during your reporting period in the appropriate item (i.e., 109, 111, 113 or 115). See the DEFINITIONS section for a definition of reportable contract labor. Round all reported hours to the nearest whole hour.

ITEMS 110, 112, 114 and 116 (Contract Labor Compensation)
Report the cost incurred for contracted nursing services performed by nonstaff Registered Nurses (RNs), including Directors of Nursing (DONs) and Assistant Directors of Nursing (ADONs), Licensed Vocational Nurses (LVNs), including DONs and ADONs, Medication Aides and Certified Nurse Aides (CNAs), including Restorative Aides, providing direct care services to residents in Medicaid-contracted beds during your reporting period in the appropriate item (i.e., 110, 112, 114 or 116). Do not include nursing services consultants, medical records consultants or contracted medical records services. See the DEFINITIONS section for a definition of reportable contract labor. Round all reported monetary amounts to the nearest whole dollar.

ITEM 117 (Payroll Taxes – FICA/Medicare)
Report FICA/Medicare taxes for direct care staff. FICA/Medicare taxes may be allocated based upon salaries; in such a situation, an acceptable allocation summary must be attached.

ITEM 118 (Does item 117 equal 7.65% of the sum of items 102, 104, 106 and 108?)
Federal regulations mandate an employer FICA/Medicare contribution of at least 7.65% of salaries. If the FICA/Medicare contributions do not equal 7.65% of the sum of items 102, 104, 106 and 108, mark this item “No” and provide a detailed explanation in the space provided below the item.

ITEM 119 (Payroll Taxes - State and Federal Unemployment)
Report both federal (FUTA) and state (TUCA) unemployment expenses for direct care staff. If this item is blank, provide a detailed explanation in the space provided below the item as to why no unemployment expenses are reported. Unemployment expenses may be allocated based upon salaries; in such a situation, an acceptable allocation summary must be attached.

ITEM 120 (Workers' Compensation – Insurance (WCI) Premiums)
If your contract, any of its controlling entities, or its parent company/sole member is a subscriber to the Workers' Compensation Act, report the WCI premiums paid to your commercial insurance carrier for direct care staff. Premium costs include the base rate, any discounts for lack of injuries, any refunds for prior period overpayments, any

additional modifiers and surcharges for experiencing high numbers of injuries (such as being placed in a risk pool).

If your contract, any of its controlling entities, or its parent company/sole member is not a subscriber to the Workers' Compensation Act, there are alternate insurance premium costs that can be reported in this item. Acceptable alternate insurance policies include industrial accident policies and other similar types of coverage for employee on-the-job injuries. Health insurance is not worker's compensation and should be reported in item 122.

If your commercially-purchased insurance policy does not provide total coverage and has a deductible and/or coinsurance clause, any deductibles and/or coinsurance payments made by the employer on behalf of the employee would be considered claims paid (i.e., self-insurance) and must be reported in item 121.

WCI premium expenses may be allocated based upon salaries; in such a situation, an acceptable allocation summary must be attached.

ITEM 121 (Workers' Compensation - Paid Claims)
Report medical claims paid for employee on-the-job injuries for direct care staff. If you were not a subscriber to the Workers' Compensation Act (i.e., traditional workers' compensation insurance policy), and you paid workers' compensation claims for employee on-the-job injuries for the direct care staff whose salaries and wages are reported in items 102, 104, 106 and 108, report the amount of claims paid in this item. If you maintained a separate banking account for the sole purpose of paying your workers' compensation claims for employee on-the-job injuries (i.e., a nonsubscriber risk reserve account), the contributions made to this banking account are not allowable. Paid claims may be direct costed or allocated based upon salaries. If paid claims are allocated, an acceptable allocation summary must be attached.

ITEM 122 (Employee Benefits - Health Insurance)
Report employer-paid health insurance for direct care staff whose salaries and wages are reported in items 102, 104, 106 and 108. Employer-paid health insurance premiums must be direct costed. Paid claims may be allocated based on salaries or direct costed. If paid claims are allocated, an acceptable allocation summary must be attached.

ITEM 123 (Employee Benefits - Life Insurance)
Report employer-paid life insurance for direct care staff whose salaries and wages are reported in items 102, 104, 106 and 108. Employer-paid life insurance premiums must be direct costed.

ITEM 124 (Employee Benefits - Other Benefits)
Report any employer-paid disability insurance and retirement contributions, deferred compensation plan contributions, child care and accrued leave for direct care staff whose salaries and wages are reported in items 102, 104, 106, and 108. These benefits must be direct costed.

The contracted provider's unrecovered cost of meals and room-and-board furnished to direct care staff, uniforms, hepatitis B vaccinations and TB testing/x-rays, staff personal vehicle mileage reimbursement, job-related training reimbursements and job certification renewal fees are not to be reported as benefits; unless they are subject to payroll taxes, in which case they are to be reported as salaries and wages. Other than mileage reimbursement for client transportation, costs that are not employee benefits and are not subject to payroll taxes are not to be reported; these costs may be reported on the provider's cost report in the appropriate items. In the space provided, describe the amount and type of each benefit comprising the total amount reported. Employee benefits must be reported in accordance with 1 TAC §355.103(b)(1)(A)(iii)(II

ITEM 125 (Total Direct Care Costs)
Sum items 102, 104, 106, 108, 110, 112, 114, 116, 117 and 119 through 124.

ITEMS 126 - 199 (Reserved for future use)
Items 126 through 199 are reserved for future use.

DAYS OF SERVICE

ITEMS 200 - 347 (Medicaid Days of Service in Medicaid-Contracted Beds)
For each Resource Utilization Group (RUG III) group enter the Medicaid days of service provided during the 9/1/12 – 4/30/13 reporting period. Report Medicaid-Hospice and Star+Plus days of service separately.

Report "pending" residents in the category you believe they are most likely to eventually be classified by DADS. For example, if you have a "pending" resident and you are uncertain as to whether they will meet financial eligibility, report their days of service in Item 350 ("Other days of service in Medicaid-contracted beds"). If you have a "pending" resident who you know met financial eligibility and all other DADS requirements and you are just waiting for the client's claim to clear through the CMS system, report the resident's days of service in the RUG group indicated by their MDS.

Days for which residents were charged for "room hold" or "bed hold" are not considered as days of service and are not to be counted as resident days. All reported Medicaid days of service will be reconciled by HHSC staff against DADS CMS paid claims data.

Item 348 reserved for future use.

ITEM 349 (Medicare Days of Service in Medicaid-contracted Beds)
Enter Medicare days of service in Medicaid-contracted beds (i.e., dually-certified beds) provided during the reporting period. Do not include Medicare days of service in Medicare-only beds.

ITEM 350 (Other Days of Service in Medicaid-contracted Beds)
Enter Other days of service in Medicaid-contracted beds (e.g., private, private insurance, VA, etc.) provided during the reporting period. Do not include Other days of service in non-Medicaid-contracted beds.

ITEM 351 (Total Days of Service in Medicaid-contracted Beds)
Enter the sum of days of service from Items 347, 349 and 350.

ITEM 352 (Days of Service in Non-Medicaid-contracted Beds)
Enter days of service in non-Medicaid-contracted beds. Include Other residents in non-Medicaid beds and Medicare residents in Medicare-only beds.

ITEM 353 (Total Days of Service) for reporting period 9/1/12 – 4/30/13
Enter the sum of days of service from Items 351 and 352.

Items 354 - 365 reserved for future use.

ITEMS 366 - 377 (Medicaid Days of Service Qualifying for Supplemental Payments for Ventilator or Pediatric Tracheotomy Care)
For residents qualifying for the Ventilator or Pediatric Tracheotomy Supplements, include their days of service by RUG group in RUGs RAD – PCE as appropriate and also enter the days they qualified for a supplement in items 366 - 377 as appropriate. For example, a RUG RAD resident who also qualified for the Ventilator-Continuous Supplement would be counted as both a RUG RAD resident and a Ventilator-Continuous resident.

NOTE ON COMPLETION OF SCHEDULES: Complete only those schedules that have an associated item reported in the body of the report. For example, if the report does not include any related-party expenses, do not complete Schedule B, etc.

SCHEDULE A: RESERVED FOR FUTURE USE

SCHEDULE B: RELATED-PARTY TRANSACTIONS

See 1 TAC §355.102(i) for specific details and requirements on related-party transactions.

The purchase of services from related organizations or related individuals by the provider or the provider's central office must be reported as related-party transactions on Schedule B.

Expenses in related-party transactions are allowable at the cost to the related organization; however, the cost must not exceed the price of comparable services that could be purchased elsewhere in an arm's-length transaction. The related organization's costs include all reasonable costs, direct and indirect, incurred in the furnishing of services to the provider. The intent is to treat the costs incurred by the supplier as if the contracted provider itself incurred them. Therefore, if a cost would be unallowable if incurred by the contracted provider itself, it would be similarly unallowable to the related organization.

See the DEFINITIONS section for a definition of related-party.

EXCEPTIONS TO THE RELATED-PARTY RULE

An exception (1 TAC §355.102(i)(5)) is provided to the general rule applicable to related organizations if the contracted provider demonstrates on each report that certain criteria have been met. If **all of the conditions** of this exception are met, the charges by the related-party supplier to the contracted provider for such services are allowable costs. **The contracted provider must submit documentation either prior to or upon submission of the cost to demonstrate that all of the following criteria have been met:**

- The supplying organization is a bona fide separate organization.
- A majority of the supplying organization's business activity is transacted with other organizations not related to the contracted provider.
- There is an open, competitive market for the type of services, furnished by the related organization.
- The services are those that commonly are obtained by entities such as the contracted provider from other organizations and are not a basic element of contracted client care.
- The charge to the contracted provider is comparable to open market prices and does not exceed the charge made to others.

If Medicare has made a determination that a related-party situation does not exist or has granted an exception to the related-party definition, and you desire that HHSC accept that determination, you must submit a **copy of the applicable Medicare determination,** along with **evidence supporting the Medicare determination for the current reporting period** with each affected report. If the exception granted by Medicare is no longer applicable due to changes in circumstances of the contracted provider or because the circumstances do not apply to the contracted provider, HHSC can choose not to accept the Medicare determination. *See 1 TAC §355.102(i)(5).*

SECTION 1A. PURCHASES AND LEASES FROM A RELATED PARTY

Section 1A should be completed if services were purchased from a related organization. If services were purchased from a related individual such as an individual owner, partner or stockholder, see Section 1B.

COMPLETION OF COLUMNS A THROUGH F

Column A (Name of Related Party/Organization) - Enter the name of the related party or organization. If the contracted provider is a proprietorship, the related organization could be the individual owner rather than a separate corporation. If the contracted provider is a partnership, the related organization could be one of the partners. Refer to the DEFINITIONS section for information regarding related parties.

Column B (Percentage of Ownership) - Enter the percent of the contracted provider owned by the related party. For example, if the contracted provider is a 50-50 partnership and the related party in Column A was one of the partners, the percentage of common ownership would be 50%. If the contracted provider is one "branch" of a central corporation and the related party in Column A was the central office, the percentage of common ownership would be 100%. If the contracted provider is a corporation and the related party in Column A was a stockholder with 2% of the stock, then the percentage of common ownership would be 2%.

The percentage of common ownership may be 0% if the related-party is deemed related due to control (including being a member of the contracted provider's Board of Directors) or the existence of an immediate family relationship (other than a spousal relationship in a community property state in which case the percentage of common ownership would be the same as the owner's/stockholder's). In situations where the percentage of common ownership is 0%, a properly cross-referenced attachment should explain how the individual meets the criteria as a related party.

Column C (Report Line Number) - Enter the line number(s) on the report where the allowable cost (the amount determined in Column F) is reported. If the allowable cost is reported on more than one line item, attach and properly cross-reference documentation showing the cost reported on each line item. If the allowable cost was allocated between line items, the attachment should include the required allocation summary information.

Column D (Description of Purchased or Leased Items/Goods/Services) - Describe the services purchased from the related party.

Column E (Cost to Provider) - This amount should be the exact cost incurred (and paid within the acceptable accrual period) by the contracted provider for the purchased services.

Column F (Cost to Related Party/Organization) - This amount should be the exact cost to the related organization and should be the amount reported on the report (in the report line item(s) shown in Column C).

SECTION 1B: SERVICES PURCHASED FROM RELATED INDIVIDUALS
Report in this section the purchase of services from a related-party individual who is not an employee of the contracted provider. If the related individual is an employee of the contracted provider, a controlling entity, or other related entity, do not complete this section, but rather complete Schedule C.

COMPLETION OF COLUMNS A THROUGH F

Column A (Name of Related-Party Individual) - Enter the name of the person who is the related party. If the contracted provider is a proprietorship, the related party could be the individual owner. If the contracted provider is a partnership, the related party could be one of the (individual) partners. Only individuals should be listed in this column; services purchased from related organizations should be reported in Section 1A, not 1B.

Refer to the DEFINITIONS section for information regarding related parties.

Column B (Percentage of Ownership) - Enter the percent of the contracted provider owned by the related individual. If the contracted provider is a 50-50 partnership and the related party in Column A was one of the partners, the percentage of common ownership would be 50%. If the contracted provider is a corporation and the related party in Column A was a stockholder with 4% of the stock, then the percentage of common ownership would be 4%.

The percentage of common ownership may be 0% if the related-party is deemed related due to control (including being a member of the contracted provider's Board of Directors) or the existence of an immediate family relationship (other than a spousal relationship in a community property state in which case the percentage of common ownership would be the same as the owner's/stockholder's). In situations where the percentage of common ownership is 0%, a properly cross-referenced attachment should explain how the individual meets the criteria as a related party.

Column C (Report Line Number) - Enter the line number(s) on the report where the allowable cost (the amount determined in Column F) is reported. If the allowable cost is reported on more than one line item, attach and properly cross-reference documentation showing the cost reported on each line item. If the allowable cost was allocated between line items, the attachment should include the required allocation summary information.

Column D (Description of Service Performed) - Enter a description of the service performed.

Column E (Total Hours Worked in Program) - Enter the total hours the related individual worked in the program during the entire reporting period. Itemized invoices and/or timesheets should substantiate the amount reported in this column. Dividing the total compensation received from Column F by the total hours worked from Column E should result in the average compensation per hour for the services described in Column D.

Column F (Total Compensation Earned) - Enter the amount of compensation the related-party individual received during the reporting period for the services described in Column D. This amount should be included in the cost report line item indicated in Column C.

SCHEDULE C: RELATED-PARTY COMPENSATION OF OWNER-EMPLOYEES AND OTHER RELATED-PARTY EMPLOYEES

This schedule must be completed by every contracted provider that has an owner-employee or other related-party employee working in the direct care area regardless of whether the owner-employee or other related-party employee received any compensation for their services during the year.

For reporting purposes, a direct care employee who meets the definition of a related party or an owner who is a sole proprietor, a partner owning 5% or more of the partnership, or a corporate stockholder owning 5% or more of the outstanding stock of the contracted provider must report their compensation on a Schedule C.

If no compensation was paid, received, or properly accrued during the reporting period for an owner-employee or a related-party employee, complete items 1 - 10 and indicate "None" or "N/A" in the remaining items. Be sure to clearly explain in item 10 why no compensation is being reported.

An organizational chart must be attached to the Schedule C indicating the owner-employee's or the related-party employee's name and position within the organization. When organizational structures are composed of several corporations and the owner-employee and/or other related-party employee is associated with more than one of the corporations, it is necessary to submit at least two organizational charts: one picturing the entire organizational structure of various corporations and one detailing the organizational structure of the corporation providing the services covered by the specific cost report.

Allowable Compensation (see 1 TAC §355.103(b)(2))

Allowable compensation for an owner-employee or other related-party employee is governed by the principles that the services rendered are necessary functions, that the compensation is for the reasonable value of services rendered, that the compensation is not based on profitability, and that the services performed do not duplicate those performed by another employee of the nursing facility.

A function is deemed necessary when, if the owner or related party had not performed said function, the nursing facility 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 resident services.

The test of reasonableness requires that the compensation of owner-employees and other related-party employees be such an amount as would ordinarily be paid for comparable services performed by non-owners or unrelated parties. Reasonable compensation is limited to the fair market value of services rendered by the owner-employee or other related-party employee in connection with resident care. Education and experience of the owner are pertinent only as they relate to the job being performed and the services being rendered

PART 1 - COMPENSATION
Complete a separate Schedule C for each employee who meets the definition of an owner-employee or other related-party employee.

Item 1 (Name) - Indicate the name (Last Name, First Name, and Middle Name/Initial) of the owner-employee or the related-party employee.

Item 2 (Title) - Indicate the title of the owner-employee or other related-party employee. The title must correspond to the title indicated on the organizational chart attached to the report.

Item 3 (Type of Position) - Identify the type of position filled by the owner-employee or other related-party employee.

Item 4 (Location of Position Within Organizational Structure) - Indicate the location of the owner-employee's or other related-party employee's position within the organizational structure by checking the appropriate box (i.e., facility, contracting entity, a controlling entity, or parent company/sole member/related-party management company). Item 4 should relate to the organizational chart(s) attached to the report.

Item 5 (Description of Duties) - Provide a description of the duties performed by the owner-employee or other related-party employee as they relate to the specific report or attach and properly cross-reference a copy of the person's written job description and provide a summary of how those duties relate to the specific report. See 1 TAC §355.105(b)(2)(B)(xi).

Item 6 (Relationship to Provider) - Indicate the owner-employee's or other related-party employee's relationship to the contracted provider. If the schedule is being completed for an owner-employee, indicate that the employee is an owner and describe the type of ownership (e.g., owner-sole proprietor; owner- % partner; owner- % stockholder). If the schedule is being completed for a related-party employee other than the owner, identify the relationship (e.g., wife of owner-sole proprietor; daughter-in-law

of % partner; brother of % stockholder). If the schedule is being completed for a member of the Board of Directors (related through control), identify that fact in this item.

Item 7 (Percentage of Ownership) - If the schedule is being completed for an owner-employee, enter the percentage of ownership for that employee. If the schedule is being completed for a related-party employee who has no ownership interest, indicate "None" as the ownership percentage. If the schedule is being completed for a related-party employee who is the spouse of an owner in a community property state, indicate the same ownership percentage as the owner.

Item 8 (Total Compensation) - Report the total amount of compensation paid to (or properly accrued by) the owner-employee or other related-party employee during the reporting period. See 1 TAC §355.103(b)(2)(A-B) and §355.105(b)(2)(B)(xi).

Total compensation includes regular salary, overtime pay, bonuses, and any other forms of compensation subject to payroll taxes, as well as any accrued compensation that had not been paid to the employee at the end of this reporting period. (Note: Accrued expenses must be paid within 180 days after the end of the reporting period in order to be allowable for reporting purposes.)

Total compensation should include compensation received from all business entities:

- Which provide similar services, regardless of the organizational structure;
- Which are organized under a single corporate "umbrella";
- Within which the employee provides long-term services, regardless of whether the business entity has a DADS contract (e.g., Medicare home health); and/or
- That are contracted with the State of Texas.

Item 9 (Number of Hours Worked) - Report the number of hours worked during the reporting period by the employee in order to earn the total compensation reported in item 8. In other words, if item 8 were divided by item 9, the result would be the employee's average compensation per hour. If the employee were a full-time, salaried employee, the number of hours reported would be 2,080 (40 hours x 52 weeks) unless documented by daily timesheets to support hours in excess of this full-time equivalency.

Item 10 (Allocation Method) - If the services provided by this employee benefited more than the contract for which the report is being completed or if the employee's salary is reported on more than one line item on this report, the salary must be either directly charged or allocated to all benefiting business entities or line items. If the salary has been directly charged, you need to state this in item 10 and describe the basis upon which the compensation has been directly charged to this report or between line items. For example, you might state that the salary has been directly charged based upon daily

timesheets, attach a copy of a completed timesheet, attach a copy of the written instructions applicable to the completion of the timesheet, report the total number of hours recorded by all timesheets during the reporting period (the denominator), report the total number of hours directly chargeable to the specific report based upon the results of the daily timesheets (the numerator), and show the calculation of the percentage of compensation directly charged to this report (a percentage with two decimal places)

NOTE: For direct care staff, time must be directly charged and allocation of time is not acceptable. The only exception to the "no allocation rule" is when nursing personnel work for both Medicaid-contracted and noncontracted licensed nursing facility beds. In such a situation, salaries and wages must be allocated between contracted and noncontracted beds based upon units of service (i.e., resident days).

PART 2 - ALLOCATION OF COMPENSATION

Item 11 (Breakdown of Total Compensation) - Provide a breakdown by business component of how the total allowable compensation reported in Item 8 was allocated or directly charged.

The owner-employee or other related-party employee must report in item 11 the total compensation received from all business entities (components) that benefit from his/her effort or work. If the business component has a state of Texas vendor/provider number, report the number and program name in the business component blank. If the business component does not have a state of Texas vendor/provider number, report the business component's name or a description of the business component.

Compensation should be directly charged to each business entity based on the level of effort involved in providing services to or working for the entity (and supported by daily timesheets). Direct care staff salaries and wages must be directly charged.

Item 12 (% of Total Compensation) - Report the percentage of the total employee compensation from item 8 that has been directly charged or allocated to this report. Report the percentage with two decimal places (i.e., 33.33%).

Item 13 (% of Total Hours) - Report the percentage of the employee's total hours (item 9) directly charged or allocated to this report. Report the percentage with two decimal places. If the percentage of hours reported in item 13 is different from the percentage of compensation reported in item 12, please provide a detailed explanation for the variance. If additional pages are required, please cross-reference any attachments.

Item 14 (Report Line Numbers) - Enter each report line number on which the salary directly charged or allocated to this report is reported. The explanation provided in item 10 should clearly explain how the amount was calculated for each report line number completed in item 14.

SCHEDULES D, E, F, G & H:

RESERVED FOR FUTURE USE

SCHEDULE I: BED ADDITIONS AND DELETIONS DURING THE REPORTING PERIOD

If your facility had any change in the number of beds licensed for nursing care by DADS or in the number of beds contracted for Medicaid nursing care during its reporting period, you must complete Schedule I and attach documentation from DADS supporting each reported change. Documentation should be in the form of a letter from DADS indicating the number of licensed and/or contracted beds after the change and the effective date of the change.

CERTIFICATION PAGES

Certification pages must contain original signatures and original notary stamps/seals. If these pages are not properly completed, the report will not be processed until the provider makes the necessary corrections. If necessary corrections are not made in a timely manner, the report will be returned as unacceptable.

Multi-facility organizations may submit one report containing original signatures and original notary stamps/seals. All other reports submitted by the multi-facility provider can be submitted with copies of the original certification pages. For multi-facility organizations that choose this option:

- the original certification pages MUST include a list of the 9-digit contract numbers of the reports being submitted with copies of the original certification pages; and

- the copies of the original certification pages MUST indicate the 9-digit contract number of the report being submitted with the original certification pages.

REPORT CERTIFICATION

This page must be completed by an individual legally responsible for the conduct of the provider or legally authorized to bind the provider, such as sole proprietor, a partner, a corporate officer, an association officer, a governmental official, a limited liability company member, a person authorized by the applicable DADS Signature Authority Designation Form (form 2031) for the interested party on file at the time of the request, or a legal representative for the interested party. The facility administrator may not sign this certification page unless he/she also holds one of those positions. The responsible party's signature must be notarized. The signature date should be the same or after the date the preparer signed the Methodology Certification page, since the report certification indicates that the report has been reviewed after preparation. Misrepresentation or falsification of any information contained in this report may be punishable by fine and/or imprisonment.

METHODOLOGY CERTIFICATION

This page must be signed by the person identified on the cover page of this report as PREPARER. This person must be the individual who actually prepared the report or who has primary responsibility for the preparation of the report for the provider. Signing as PREPARER carries the responsibility for an accurate and complete report prepared in accordance with applicable methodology rules and instructions and that the preparer has either completed the report himself/herself in accordance with those rules and instructions or has adequately supervised and thoroughly instructed his/her employees in the proper completion of the report. Ultimate responsibility for the report lies with the person signing as PREPARER. If more than one person prepared the report, an executed Methodology Certification page (with original signatures and original notary stamp/seal) may be submitted by each preparer.

NOTE*:* Each person signing as preparer must have attended the HHSC state-sponsored Cost Report Training for the 2011 or 2012 Nursing Facility Cost Report or successfully completed the general and nursing facility-specific online cost report tests for the 2011 or 2012 cost reports, and a valid completion certificate must be attached to the report for each preparer. If a valid completion certificate is not attached, the report will not be processed until such time as the required certificates are provided. If the required certificate is not provided in a timely manner, the report will be returned as unacceptable.

STATE OF TEXAS COUNTY CODES

County Name /	Code	County Name /	Code	County Name /	Code	County Name /	Code	County Name /	Code
Anderson	001	Crockett	053	Hays	105	Mason	157	Shackelford	209
Andrews	002	Crosby	054	Hemphill	106	Matagorda	158	Shelby	210
Angelina	003	Culberson	055	Henderson	107	Maverick	159	Sherman	211
Aransas	004	Dallam	056	Hidalgo	108	McCulloch	160	Smith	212
Archer	005	Dallas	057	Hill	109	McLennan	161	Somervell	213
Armstrong	006	Dawson	058	Hockley	110	McMullen	162	Starr	214
Atascosa	007	Deaf Smith	059	Hood	111	Medina	163	Stephens	215
Austin	008	Delta	060	Hopkins	112	Menard	164	Sterling	216
Bailey	009	Denton	061	Houston	113	Midland	165	Stonewall	217
Bandera	010	DeWitt	062	Howard	114	Milam	166	Sutton	218
Bastrop	011	Dickens	063	Hudspeth	115	Mills	167	Swisher	219
Baylor	012	Dimmit	064	Hunt	116	Mitchell	168	Tarrant	220
Bee	013	Donley	065	Hutchinson	117	Montague	169	Taylor	221
Bell	014	Duval	066	Irion	118	Montgomery	170	Terrell	222
Bexar	015	Eastland	067	Jack	119	Moore	171	Terry	223
Blanco	016	Ector	068	Jackson	120	Morris	172	Throckmorton	224
Borden	017	Edwards	069	Jasper	121	Motley	173	Titus	225
Bosque	018	Ellis	070	Jeff Davis	122	Nacogdoches	174	Tom Green	226
Bowie	019	El Paso	071	Jefferson	123	Navarro	175	Travis	227
Brazoria	020	Erath	072	Jim Hogg	124	Newton	176	Trinity	228
Brazos	021	Falls	073	Jim Wells	125	Nolan	177	Tyler	229
Brewster	022	Fannin	074	Johnson	126	Nueces	178	Upshur	230
Briscoe	023	Fayette	075	Jones	127	Ochiltree	179	Upton	231
Brooks	024	Fisher	076	Karnes	128	Oldham	180	Uvalde	232
Brown	025	Floyd	077	Kaufman	129	Orange	181	Val Verde	233
Burleson	026	Foard	078	Kendall	130	Palo Pinto	182	Van Zandt	234
Burnet	027	Fort Bend	079	Kenedy	131	Panola	183	Victoria	235
Caldwell	028	Franklin	080	Kent	132	Parker	184	Walker	236
Calhoun	029	Freestone	081	Kerr	133	Parmer	185	Waller	237
Callahan	030	Frio	082	Kimble	134	Pecos	186	Ward	238
Cameron	031	Gaines	083	King	135	Polk	187	Washington	239
Camp	032	Galveston	084	Kinney	136	Potter	188	Webb	240
Carson	033	Garza	085	Kleberg	137	Presidio	189	Wharton	241
Cass	034	Gillespie	086	Knox	138	Rains	190	Wheeler	242
Castro	035	Glasscock	087	Lamar	139	Randall	191	Wichita	243
Chambers	036	Goliad	088	Lamb	140	Reagan	192	Wilbarger	244
Cherokee	037	Gonzales	089	Lampasas	141	Real	193	Willacy	245
Childress	038	Gray	090	LaSalle	142	Red River	194	Williamson	246
Clay	039	Grayson	091	Lavaca	143	Reeves	195	Wilson	247
Cochran	040	Gregg	092	Lee	144	Refugio	196	Winkler	248
Coke	041	Grimes	093	Leon	145	Roberts	197	Wise	249
Coleman	042	Guadalupe	094	Liberty	146	Robertson	198	Wood	250
Collin	043	Hale	095	Limestone	147	Rockwall	199	Yoakum	251
Collingsworth	044	Hall	096	Lipscomb	148	Runnels	200	Young	252
Colorado	045	Hamilton	097	Live Oak	149	Rusk	201	Zapata	253
Comal	046	Hansford	098	Llano	150	Sabine	202	Zavala	254
Comanche	047	Hardeman	099	Loving	151	San Augustine	203		
Concho	048	Hardin	100	Lubbock	152	San Jacinto	204		
Cooke	049	Harris	101	Lynn	153	San Patricio	205		
Coryell	050	Harrison	102	Madison	154	San Saba	206		
Cottle	051	Hartley	103	Marion	155	Schleicher	207		
Crane	052	Haskell	104	Martin	156	Scurry	208		