

Health and Human Services Commission (HHSC)

Dental Services Supplemental Payment Program

Cost Report Instructions (Revised 1-31-13)

**INSTRUCTIONS FOR COMPLETING THE
DENTAL SERVICES SUPPLEMENTAL PAYMENT PROGRAM COST REPORT**

General:

Governmentally owned dental providers are eligible to participate in the supplemental payment program if they are directly funded by a local government, hospital authority, hospital district, city, county or state as specified in 42 CFR § 433.50 (i) which describes a unit of government. This would include providers such as public health clinics and departments, dental schools, mobile dental units or other dental facilities that are owned by the government. Providers wanting to participate in the program should contact the Texas Health and Human Services Commission (HHSC), Rate Analysis Department at (512) 730-7401.

The cost report will include only allocable expenditures related to Medicaid, Medicaid Managed Care and Uncompensated Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program.

The Dental Services Supplemental Payment Cost Report (cost report) must be prepared and completed on an annual basis for federal fiscal years ending on September 30. Cost reports are due to HHSC 180 days after the close of the applicable reporting period. An eligible provider who has been approved to submit a cost report for supplemental payment will prepare the cost report, attest to and certify the total actual Medicaid costs/expenditures. The completed cost report will be sent to:

HHSC Rate Analysis/Acute Care Services
Brown Heatly Building
Mail Code H-400
4900 North Lamar
Austin, TX 78751-2399

When using the Excel spreadsheet, many fields in the pages will automatically populate with information from another worksheet to avoid additional data entry and reduce errors. Therefore, only the **SHADED AREAS** of the cost report are to be completed. Please review and verify the accuracy of all information on the pages before completing the report.

For questions on completing the cost report, please contact the Health and Human Services Commission, Rate Analysis Department at (512) 730-7401.

Definitions:

Cognizant agency—the 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.

Commercial Pay Insurance—health insurance that covers medical expenses and disability income for the insured. Commercial health insurance can be categorized according to its renewal provisions and type of medical benefits provided. Commercial policies can be sold individually or as part of a group plan.

**INSTRUCTIONS FOR COMPLETING THE
DENTAL SERVICES SUPPLEMENTAL PAYMENT PROGRAM COST REPORT**

Cost Allocation Plans—are the means by which costs are identified in a logical and systematic manner for reimbursement under federal grants and agreements.

Cost-to-charge-ratio (CCR)— a provider's reported costs are allocated to the Medicaid program based on a cost-to-billed-charge ratio. Cost-to-billed charge ratio is calculated as total allowable cost reported for the service period divided by total billed charges for the service period. This ratio is then applied to total billed charges associated with Medicaid paid claims to calculate total allowable billed charges for the cost report.

Direct Cost—means any cost which is identified specifically with a particular final cost objective. Direct costs are not limited to items which are 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 Percentage (FMAP)—the share of state Medicaid benefit costs paid for by the federal government.

Indirect Costs—cost incurred and identified with having two or more cost objectives but not specifically identified with any final cost objective.

Indirect Cost Rate—a device for determining in a reasonable manner the proportion of indirect costs each program should bear. It is the ratio, expressed as a percentage, of the indirect costs to the direct costs.

Intergovernmental Transfers (IGT)—State and local funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity and eligible for federal match under the 1115 Transformation Waiver. This does not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

Medicaid Fee-For-Service (FFS)—the traditional health care payment system, in which providers receive a payment for each unit of service they provide

Medicaid Managed Care (MCO)—an entity that provides or contracts for managed health care. Medicaid payments are made by the MCOs to providers for services provided to Medicaid recipients.

Medicare—a federal system of health insurance for those who are 65 and older, disabled or have permanent kidney failure.

Self-Pay—an individual who either does not have insurance or her/his insurance does not cover a particular procedure or provider and therefore, the individual is responsible for paying the provider.

Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver—the vehicle approved by HHSC and CMS for implementation of the waiver program under section 1115 of the Social Security Act.

**INSTRUCTIONS FOR COMPLETING THE
DENTAL SERVICES SUPPLEMENTAL PAYMENT PROGRAM COST REPORT**

Uncompensated Care (UC)—costs of uncompensated care provided to Medicaid eligibles or to individuals who have no funds or third party coverage for services provided by medical, dental or other providers.

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

Uninsured cost--the cost to provide dental services to uninsured patients as defined by the Centers for Medicare and Medicaid Services. 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 unit in the State that: has taxing authority, has 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).

Page 1: Cover Page

Page 1 is the cost report cover page. This form includes a provider's national and state provider identification numbers. Each governmental provider enters its legal name and the appropriate contact information for all parties listed on the form. This information will be used by HHSC to contact the provider during the cost reconciliation and settlement process.

DIRECTIONS TO COMPLETE PAGE 1

Federal Fiscal Year: Enter the federal fiscal year for which the cost report will be completed (e.g., 2012). When this is entered on the cover page, this field will automatically transfer to subsequent pages.

Reporting Period: Enter the actual reporting period for which the cost report will be completed (e.g., 10/01/11 to 09/30/12). When this is entered on the cover page, this field will automatically transfer to subsequent pages.

Texas Provider Identification Number (TPI): Enter the 9-digit TPI number for the provider that is completing the cost report. When this is entered on the cover page, this field will automatically transfer to subsequent pages.

National Provider Identification Number (NPI): Enter the 10-digit NPI number for the provider that is completing the cost report. When this is entered on the cover page, this field will automatically transfer to subsequent pages.

Provider Information

Provider Name: Enter the provider's legal name (e.g., Laredo Health Department Dental Clinic)

Provider Contact Name: Enter the provider's contact

**INSTRUCTIONS FOR COMPLETING THE
DENTAL SERVICES SUPPLEMENTAL PAYMENT PROGRAM COST REPORT**

Street Address: Enter the street address and also include the city, state, and zip code in this field.

Mailing Address: Enter the mailing address and also include the city, state, and zip code in this field.

Phone Number: Enter the phone number of the provider's contact.

Fax Number: Enter the fax number of the provider's contact.

Email: Enter the email of the provider's contact.

Chief Financial Officer / Business Manager

Name: Enter the name of the chief financial officer or business manager.

Title: Enter the title of the chief financial officer or business manager.

Business Name: Enter the business name (e.g. UT Health Science Center at San Antonio Dental School).

Mailing Address: Enter the mailing address and also include the city, state, and zip code in this field.

Phone Number: Enter the phone number of the chief financial officer or business manager.

Fax Number: Enter the fax number of the chief financial officer or business manager.

Email: Enter the email of the chief financial officer or business manager.

Report Preparer Identification

Name: Enter the name of the person responsible for preparing the cost report (this is the person HHSC should contact if there are questions).

Title: Enter the title of the report preparer.

Business Name: Enter the business name (e.g. UT Health Science Center at San Antonio Dental School).

Mailing Address: Enter the mailing address and also include the city, state, and zip code in this field.

Phone Number: Enter the phone number of the report preparer.

Fax Number: Enter the fax number of the report preparer.

Email: Enter the email of the report preparer.

Location of Accounting Records that Support this Report

Physical Address: Enter the Physical Address of the location where the provider maintains the accounting records that support the cost report and include the city, state, and zip code in this

**INSTRUCTIONS FOR COMPLETING THE
DENTAL SERVICES SUPPLEMENTAL PAYMENT PROGRAM COST REPORT**

field. When this is entered on the cover page, this field will automatically transfer to the subsequent pages.

Page 2: General and Statistical Information

DIRECTIONS TO COMPLETE PAGE 2

Page 2 is the General and Statistical Information page of the cost report. This page includes general provider and statistical information used in the cost report.

General Provider Information

1.00-1.03: These fields will automatically transfer from the Cover Page.

1.04: Enter either yes or no to indicate if the reporting period is less than a full federal fiscal year. If the cost report is being prepared for a partial fiscal quarter, enter a response that explains the reason why (e.g., no, Supplemental Payment Request Approval was effective beginning 3/1/20XX).

Cost Allocation Information

The purpose of this section is to obtain summary information regarding the cost allocation methodology the governmental entity utilized to allocate costs to various programs, grants, contracts and agreements. Additional information required to support an agency's methodology will be found on Page 7 Worksheet C.

1.05: Enter either yes or no to indicate whether your agency has an approved Cost Allocation Plan (CAP). Additional information must be provided on Page 7 Worksheet C.

1.06: If the answer to 1.05 is yes, enter the name of the Cognizant Agency.

1.07: Enter yes or no to indicate whether your agency has an approved Indirect Cost Rate (IDCR).

1.08: If the answer to 1.07 is yes, enter the name of the Cognizant Agency.

1.09: Enter either yes or no to indicate whether your agency will be using an IDCR on this report.

1.10: If the answer to 1.09 is yes, enter the IDCR Statistical Information.

1.11: Medicaid Fee-For-Service (FFS) Paid Claims Amount: Enter the total.

1.12: Total Medicaid FFS Billed Charges Associated with Medicaid Paid Claims: Enter the total.

1.13: Medicaid Managed Care Organization (MCO) Paid Claims Amount: Enter the total.

1.14: Total FFS Billed Charges Associated with Medicaid Paid Claims: Enter the total.

1.15: Uncompensated (Uninsured) Care Reimbursement: Enter the total.

1.16: Uncompensated (Uninsured) Care Billed Amount: Enter the total.

**INSTRUCTIONS FOR COMPLETING THE
DENTAL SERVICES SUPPLEMENTAL PAYMENT PROGRAM COST REPORT**

1.17: Total Allowable Costs for Reporting Period: This field will automatically transfer from Page 3 – Dental Cost Settlement, 2.40). This amount includes Medicaid FFS, Medicaid MCO and Uncompensated Care cost only.

1.18: Total Paid Claims and UC Reimbursement: This field will automatically add the total paid claims from Medicaid Fee-for-Service (line 1.11), MCOs (line 1.13) and UC reimbursement (line 1.15).

1.19: Total Billed Charges: This field will automatically add the total billed charges from Medicaid Fee-for-Service (line 1.12), Medicaid Managed Care Organizations (line 1.14) and UC Billed Amount (line 1.16).

Additional Cost Data (For Informational Purposes Only)

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

1.20: Medicare Costs: Enter the total.

1.21: Other (Self-Pay, Commercial Pay, etc.) Costs: Enter the total.

Page 3: Dental Cost Settlement

DIRECTIONS TO COMPLETE PAGE 3

Page 3 identifies and summarizes all dental services costs. Much of the information contained within this page is automatically pulled from other pages; however, there are unique items of cost that must be entered in this page.

Only allocable expenditures related to Medicaid Fee-for-Service, 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.

Direct cost methods must be used whenever reasonably possible. Direct costing means that allowable costs, direct or indirect, incurred for the benefit of, or directly attributable to, a specific business component must be directly charged to that particular business component. Direct cost accounting may include:

1. Dedicated Cost Centers: Cost may be included for those cost centers that are solely dedicated to Medicaid and Uncompensated Care.
2. Multiple Cost Centers: Cost may be included for those cost centers that are not solely dedicated to Medicaid and Uncompensated Care. However, the provider must submit a detailed approved Cost Allocation Plan (CAP). If cost allocation is necessary for cost-reporting purposes, governmental providers must use reasonable methods of allocation and must be consistent in their use of allocation methods for cost-reporting purposes across all program areas and business entities. The allocation method should be a reasonable reflection of the actual business operations. Allocation methods that do not reasonably reflect the actual business operations and resources expended toward each unique business entity are not acceptable. Allocated costs are adjusted if HHSC considers the allocation method to be unreasonable. The provider must submit a detailed summary of their cost allocation methodology including a description of the components, the formula for calculating the percentage and any additional supporting documentation as

**INSTRUCTIONS FOR COMPLETING THE
DENTAL SERVICES SUPPLEMENTAL PAYMENT PROGRAM COST REPORT**

required by HHSC. Supplemental schedules must also be attached to the cost report listing each employee, job title, total salary and benefits, the applicable allocation percentage and the allocation amount that will be included in the cost report. The amounts from the supplemental schedule allocated to the Medicaid and Uncompensated Care programs should match the amounts entered on Page 6 Worksheet B with additional detail entered on Page 7 Worksheet C.

If Indirect Cost (IDC) is included, that amount should be listed in line 2.30 (Other) with the detail described in either the Explanation Box or as a separate attachment. Indirect cost is calculated by multiplying the **Total Allowable** costs by the provider's approved indirect cost rate. IDCR detail should include the methodology for determining the IDCR, the percentage and amount of the IDCR and if the dental provider is already using the IDCR to claim cost on another report. If IDCR costs are claimed in line 2.30, indirect or administrative costs cannot also be claimed as non-clinical cost in lines 2.26 a., 2.27 a. or in administrative salaries and compensation in Page 6 (Worksheet B). IDCR costs may be disallowed if it is determined that the provider has already claimed those same IDCR costs on this or another report. Additional detail regarding an agency's IDCR must be provided on Page 7 Worksheet C.

This page sums the payroll expenses and adds other costs to calculate the total cost of dental services. Identified reductions, either from Page 6 or entered manually with descriptions in the Explanation Box, are subtracted to calculate the adjusted amount of dental costs allowable as part of the cost report. The cost report identifies the portion of allowable costs that are related to Medicaid FFS, Medicaid MCOs, and Uncompensated Care and applies the cost-to-charge-ratio applicable for the cost report period. This ratio is applied to billed charges associated with Medicaid FFS and MCO paid claims and Uncompensated Care billed charges resulting in the total computable amount for dental services. This amount is then reduced by Medicaid FFS, Medicaid MCO paid claims and any reimbursement received for Uncompensated Care. The resulting amount is then multiplied by the applicable federal medical assistance percentage (FMAP) to calculate the Federal and state amounts. The page is separated into the sections identifying:

Personnel/Payroll Expenses

2.00-2.21: If using hours as an allocation method enter the number of hours. Total paid hours include but are not limited to regular wage, sick and vacation hours. If personnel/payroll expenditure data is entered on Page 6 – Worksheet B – Payroll and Benefits, those costs will automatically transfer to this page.

2.22: State Unemployment Payroll Taxes: Enter the total (if applicable).

2.23: Federal Unemployment Payroll Taxes: Enter the total (if applicable).

2.24: Unemployment Compensation (Reimbursing Employer): Enter the total (if applicable).

2.25: Total Staff Costs: Will automatically calculate (sum of applicable items in 2.00-2.24).

Other Costs

**INSTRUCTIONS FOR COMPLETING THE
DENTAL SERVICES SUPPLEMENTAL PAYMENT PROGRAM COST REPORT**

2.26: Supplies and Materials: Supplies and materials include but are not limited to dental and medical supplies, office supplies, and maintenance supplies. Supplies and materials must be separated according to whether they are non-clinical or clinical. The total for non-clinical supplies and materials would be entered on 2.26 a. and the total for clinical supplies and materials would be entered on 2.26 b. Detail describing the supplies and materials along with the amount and allocation methodology should be entered in the Explanation Box or attached as a separate sheet. If a cognizant-agency- approved indirect cost rate is used, additional administrative (non-clinical) cost will not be permitted.

2.27: Equipment: Equipment costs include but are not limited to dental and medical equipment, computers and communication equipment. Equipment costs must be separated according to whether they are non-clinical or clinical. The total for non-clinical equipment would be entered on 2.27 a. and the total for clinical equipment would be entered on 2.27 b. Detail describing the equipment costs along with the amount and allocation methodology should be entered in the Explanation Box or attached as a separate sheet. If a cognizant-agency- approved indirect cost rate is used, additional administrative (non-clinical) cost will not be permitted.

2.28: Support Services: Enter the total and provide detail in the Explanation Box. Support services expenditures may include personnel and non-personnel expenditures such as information technology salaries and benefits and operating expenditures.

2.29: Depreciation: Depreciation information should first be entered on Page 5 – Schedule A – Depreciation and those costs will automatically transfer to this line.

2.30: Other: Enter the total and provide detail in the Explanation Box.

2.31: Total Direct and Indirect Dental Other Costs: Will automatically calculate (sum of 2.26 through 2.30).

2.32: Total Staff, Direct and Indirect Dental Other Costs: Will automatically calculate (sum of 2.25 and 2.31).

Reductions

2.33: Other Federal Funds and Grants: If expenditure data is entered on Page 6 – Worksheet B Payroll and Benefits, those costs will automatically transfer to this line.

2.34: Other: Enter the total and provide detail in the Explanation Box.

2.35: Total Reductions: Will automatically calculate (sum of 2.33 and 2.34).

Cost Settlement Calculation

2.40: Total Allowable Costs: Will automatically calculate (2.32 less 2.35).

2.41: Total Billed Charges: This field will automatically transfer from Page 2 – General & Statistical, 1.19.

2.42: Cost-to-Charge-Ratio (CCR) = Total Allowable Costs/Total Billed Charges: Will automatically calculate (2.40 divided by 2.41)

**INSTRUCTIONS FOR COMPLETING THE
DENTAL SERVICES SUPPLEMENTAL PAYMENT PROGRAM COST REPORT**

2.43: Total Billed Charges Associated with Medicaid Paid Claims and Uncompensated Care: This field will automatically transfer from Page 2 – General & Statistical, (sum of 1.06 and 1.08).

2.44: Medicaid Allowable Costs = CCR * Total Billed Charges Associated with Medicaid Paid Claims and Uncompensated Care: Will automatically calculate (2.42 multiplied by 2.43).

2.45: Total Medicaid Allowable Billed Charges: This field will automatically calculate the lesser of 2.43 or 2.44; this amount cannot exceed 2.43, Total Billed Charges Associated with Medicaid Paid Claims and Uncompensated Care).

2.46: Medicaid Paid Claims Amount and Uncompensated Care reimbursement: This field will automatically transfer from Page 1 – General & Statistical (sum of 1.05 and 1.07).

2.47: Settlement Amount = Total Medicaid Allowable Billed Charges and Uncompensated Care Charges minus Medicaid Paid Claims Amount and Uncompensated Care Reimbursement: Will automatically calculate 2.45 minus 2.46

2.48: FMAP (Federal Medical Assistance Percentage): HHSC will enter the correct FMAP.

2.49: Federal Funds = Settlement Amount * FMAP: Will automatically calculate (2.47 multiplied by 2.48).

2.50: State Funds (IGT Amount): Will automatically calculate 2.47 less 2.49). Governmental entities are required to certify on Page 4 Cost Report Certification that they have completed the appropriate documentation required by HHSC and the Texas Comptroller’s Office regarding the Intergovernmental Transfer (IGT) process. Once the cost report has been reviewed and accepted by HHSC, the provider will be notified of the amount required for the IGT.

Page 4 – Cost Report Certification

DIRECTIONS TO COMPLETE PAGE 4

Page 4 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 and that the report was prepared in accordance with State and Federal audit and cost principle standards. The signer is also certifying that the expenditures included in this cost report have not been claimed on any other cost report.

Most of the information in Page 4 will be updated automatically with information from previous pages. This page must be signed and included **UPON COMPLETION OF ALL OTHER PAGES**.

Upon completion of all other pages in the cost report, please have the appropriate person read and sign the form. **Scan and include the signed page** when sending the electronic version of the cost report to HHSC.

Signature Authority/Certifying Signature

Printed/Typed Name of Signer: Enter the name of the person that will be certifying the costs identified in the cost report.

Title of Signer: Enter the title of the signer.

**INSTRUCTIONS FOR COMPLETING THE
DENTAL SERVICES SUPPLEMENTAL PAYMENT PROGRAM COST REPORT**

Name of Provider: Enter the name of the Provider.

Address of Signer: Enter the address of the signer.

Phone Number: Enter the phone number of the signer.

Fax Number: Enter the fax number of the signer.

Email: Enter the email of the signer.

Signature of Signer and Date: The signer should sign and date the form.

Page 5 – Schedule A - Depreciation

DIRECTIONS TO COMPLETE PAGE 5

Page 5 identifies allowable depreciation expenses incurred by the provider for that portion which is related to Medicaid, Medicaid Managed Care and Uncompensated Care. This page will identify all depreciable assets for which there was a depreciation expense during the Cost Report period. Information on this page must come from a depreciation schedule maintained by the provider in accordance with straight line depreciation guidelines.

Vehicles, Equipment, Building, Etc.

For depreciation expenses, the straight line method should be used.

Asset Description: Enter the name and description of the asset. 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.

Years Useful Life: Enter the number of years of useful life of the asset.

Cost: Enter the amount of initial cost.

Prior Period Accumulated Depreciation: Enter the amount of prior period accumulated depreciation.

Depreciation for Reporting Period: Enter the amount of current period depreciation expense.

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 initial cost of the asset as identified on the provider's depreciation schedule.

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. For depreciation expense related to buildings where the provider's vehicles or staff is housed with other agencies or entities, **ONLY the portion related to the provider** may be

**INSTRUCTIONS FOR COMPLETING THE
DENTAL SERVICES SUPPLEMENTAL PAYMENT PROGRAM COST REPORT**

reported. If this is the case, the provider must attach a supplemental page showing how the portion of the building related to the provider was calculated.

Page 6 – Worksheet B – Payroll and Benefits

DIRECTIONS TO COMPLETE PAGE 6

Page 6 includes the salary and benefits, and appropriate reductions for contract and employed staff related to the provision of dental services. Data entered on this page is only for that portion of an employee's salary and benefits that is applicable to Medicaid FFS, Medicaid MCOs and Uncompensated Care. Salary and compensation must be reported on a direct charge basis. This page includes several pre-populated staffing classifications for which information will need to be completed. These pre-populated classifications include:

Director: salary and benefit expenditures related to developing, administration, and overall operational effectiveness of the organization including strategic planning, leadership and oversight, including but not limited to:

- Director
- Director's Assistant

Dental Director: salary and benefit expenditures related to planning, developing, scheduling, and the implementation of dental program services and activities, including but not limited to:

- Dental Director
- Dental Director's Assistant

Dentists and Dental Assistants: salary and benefit expenditures related to dental care including but not limited to:

- Dentists
- Dental Assistants

Safety Officer:

- Safety Officer
- Safety Officer Assistants

Billing Account Representatives: salary and benefit expenditures related to verification of patients' insurance coverage, including Medicaid, collection of third party insurance submissions and payments, and patient service related tasks, including but not limited to:

- Billing Representatives
- Account Representatives
- Patient Account Representative

**INSTRUCTIONS FOR COMPLETING THE
DENTAL SERVICES SUPPLEMENTAL PAYMENT PROGRAM COST REPORT**

Quality Assurance Technicians: salary and benefit expenditures related to analyzing performance and quality improvement program including but not limited to:

- Quality Assurance Technicians

For each employee, the following information must be included:

Employee Information

Employee #: Enter the employee #.

Last Name: Enter the last name.

First Name: Enter the first name.

Job Title/ Credentials: Enter the job title/credentials.

Employee (E) /Contractor (C): Enter the appropriate designation, either an E or a C, for the employee.

Payroll and Benefits

Gross Salary: Enter the gross salary amount.

Contractor Payments: Enter the amount of contractor payments for the employee.

Employee Benefits: Enter the amount. This includes all benefits that are not discretely identified in Columns J-L of this page.

Employer Retirement: Enter the amount.

FICA: Enter the amount of FICA.

Medicare Payroll Taxes: Enter the amount.

Federal Funding Reductions

This section of the page is designed to identify the federal funding, or other payroll and benefit expenditure reduction necessary for the specific job classifications identified above. This section of the page is also designed to discretely identify the payroll and benefit expenditures for any individual employee/contractor that must have a portion of their salary and/or benefits reduced from allowable expenditures on the Cost Report. For each of the job classifications identified above, the following information must be included:

Allocated Funded Positions Entry: Enter the appropriate designation, either yes or no, for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. A yes in this field designates an employee for which a portion or all of their

**INSTRUCTIONS FOR COMPLETING THE
DENTAL SERVICES SUPPLEMENTAL PAYMENT PROGRAM COST REPORT**

salary and benefit expenditures are funded by federal funds or grants. An no in this field designates an employee whose entire salary or a portion of whose salary and benefit expenditures are not funded by federal funds or grants, but whose costs still need to be removed from allowable expenditures as reported on the Cost Report.

Federal Funding: If the answer to the field previously is yes, then enter the amount of federal funding related to the employee's salary and benefits that must be reduced from the total allowable costs.

Other Funds: Enter the other amount to be removed related to the employee's salary and benefits that must be reduced from the total allowable costs.

Total Reduction: Will automatically calculate (sum of federal funding and other funds).

Page 7 – Worksheet C – Cost Allocation Methodologies

DIRECTIONS TO COMPLETE PAGE 7

Page 7 details the cost allocation methodologies employed by the governmental entity.

- A. If you entered “yes” on Page 2, Line 1.05, please provide a copy of your agency's approved Cost Allocation Plan (CAP).
- B. If you entered “yes” on Page 2, Line 1.06 and 1.09, please provide a copy of your agency's approved Indirect Cost Rate (IDCR).
- C. If you do not have an approved CAP or IDCR but are using another cost allocation methodology, please provide a copy of your methodology and the supporting documentation.
- D. Please provide a list of personnel cost worksheets that support your CAP or IDCR.

**INSTRUCTIONS FOR COMPLETING THE
DENTAL SERVICES SUPPLEMENTAL PAYMENT PROGRAM COST REPORT**

Appendix A - List of Participating Providers

University of Texas at San Antonio Health Science Center (UTHSC-SA) Dental School:
performs the patient billing activities for the dental school, the mobile dental unit, the Ricardo
Salinas Dental Clinic and the Laredo Health Department Dental Clinic.