



***SPECIFIC INSTRUCTIONS
for the completion of the***

***TEXAS SCHOOL HEALTH AND RELATED
SERVICES (SHARS) COST REPORT***

For assistance with the completion
of the cost report, contact:

SHARS Rate Analyst
512-730-7400 (FAX: 512-730-7454)
E-mail: ra_shars@hhsc.state.tx.us

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

Data Development Specialist
512-730-7454 (FAX: 512-730-7475)

Updated November 21, 2013
TEXAS HEALTH AND HUMAN SERVICES COMMISSION (HHSC)

GENERAL INSTRUCTIONS

Medicaid services provided by school districts in Texas to Medicaid-eligible students are known as School Health and Related Services (SHARS). The oversight of SHARS is a cooperative effort between the Texas Education Agency (TEA) and Health and Human Services Commission (HHSC). SHARS allow local school districts, including public charter schools, to obtain Medicaid reimbursement for certain health-related services documented in a student's Individualized Education Program (IEP).

Refer to the Reimbursement Methodology rules for SHARS at Title 1 of the Texas Administrative Code, Part 15, Chapter 355, SubChapter J, Division 23, Rule 8443 and the SHARS Cost Report Training materials to answer questions related to allowable and unallowable costs and to supplement these instructions. It is the responsibility of each Medicaid provider to submit accurate and complete information on the cost report, in accordance with all pertinent published Texas Health and Human Services Commission (HHSC) cost-reporting rules and instructions.

Important: CMS requires existing SHARS providers to participate in the Random Moment Time Study (RMTS) to be eligible to bill and receive reimbursement for SHARS direct services. SHARS providers must comply with the Texas Time Study Implementation Guide for Direct Medical Services and Medicaid Administrative Claiming effective April 25, 2007, which includes but is not limited to: Mandatory Annual Program Contact training, certification of all RMTS participants for the three RMTS quarters conducted, and compliance with all sampling and participation requirements. The three RMTS quarters are October through December, January through March, and April through June.

Existing SHARS providers that do not participate in one of the three required RMTS quarters or are RMTS non-compliant cannot be a SHARS provider for that annual cost report period and will be required to return any Medicaid payments received for SHARS delivered during that annual cost report period. The school district can return to the SHARS program the following cost report period.

New SHARS providers may not bill or be reimbursed prior to the RMTS quarter in which they begin participating in and must participate in all future RMTS quarters.

School districts can access the Texas Time Study Implementation Guide for Direct Medical Services and Medicaid Claiming Effective April 25, 2007 on the HHSC website at <http://www.hhsc.state.tx.us/rad/time-study/ts-isd.shtml> by clicking on the link titled RMTS Implementation Guide.

COST REPORT AND DUE DATE SCHEDULE

The Cost Report is being provided by HHSC to each Medicaid provider in an automated format. The due date for the automated cost report is on or before April 1. Mail all required Schedules and Attachments, with original signatures and notarizations 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

When submitting by mail, remember to include MAIL CODE H-400 in the address. When submitting through a special mail delivery/courier service, include both MAIL CODE H-400 and 512-424-6500 to facilitate receipt.

REPORTING PERIOD

The Centers for Medicare & Medicaid Services (CMS) policy states that the Texas Health and Human Services Commission (HHSC) require the SHARS Cost Report reporting period to be a federal fiscal year (FFY).

PROVIDERS MUST SUBMIT AN ACCEPTABLE COST REPORT

In accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 355, SubChapter J, Division 23, Rule 8443, each School Health and Related Services (SHARS) provider will complete an annual cost report for all SHARS services delivered during the previous FFY covering October 1 through September 30.

Each SHARS provider who is a member of a cooperative or shared services arrangement must submit a separate SHARS Cost Report.

Each provider must submit financial and statistical information via the web based cost report system and certification forms provided by the HHSC Rate Analysis Department.

The amounts reported on the cost report must reconcile to your trial balance and general ledger accounts. It is recommended that you prepare one spreadsheet tracing the amounts from your trial balance and general ledger accounts to each line of the cost report and a second spreadsheet tracing the amounts from each line of the cost report back to your trial balance and general ledger accounts.

RATE ANALYSIS DEPARTMENT WEBSITE

You may retrieve information from the Rate Analysis Department website:
<http://www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml>.

FAILURE TO FILE AN ACCEPTABLE COST REPORT

Failure to file a complete and acceptable cost report by the cost report due date in accordance with instructions and rules will result in vendor hold until an acceptable and complete cost report is received by HHSC.

EXTENSIONS FOR COST REPORTS GRANTED ONLY FOR GOOD CAUSE

Extensions of cost report due dates are limited to those requested for good cause. Good cause refers to those extreme circumstances that are beyond the control of the provider and for which adequate advance planning and organization would not have been of any assistance. Written requests for an extension must be received at least 15 working days prior to the original due date of your cost report, allowing 10 working days for HHSC staff to make written response. The extension request must clearly explain the necessity for the extension and specify the extension due date being requested.

Not being aware of the due date, inconvenience of the due date, the preparer being engaged in other work so the cost report cannot be completed, or the preparer or signer not being available to sign the cost report do not meet the criteria for good cause and are not acceptable reasons to grant an extension of the due date for submission of the cost report.

ROUNDING MONETARY AMOUNTS

Round all monetary amounts to the nearest whole dollar (with no zeros included for "cents"), unless otherwise specifically directed. For example, \$25.49 should be rounded to \$25 and \$25.50 should be rounded to \$26. Cost reports submitted without proper rounding of monetary amounts may be returned for proper completion.

REPORTING DATA/STATISTICS

All applicable questions must be completed to allow the tracking of future changes or trends. Statistical data must be reported to two decimal places. For example, when reporting the hours paid for employees and contracted staff, 150 hours and 30 minutes would be reported as 150.50 hours and 150 hours and 20 minutes would be reported as 150.33 hours. Cost reports submitted without appropriate decimal places, as specified on the cost report form, may be returned for proper completion.

"PROVIDE DESCRIPTION IN EXPLANATION BOX"

When asked to "Provide description in the Explanation Box", provide an itemization of the total amount reported in the item, including the name of each category of expense and the dollar amount applicable to each expense category. If only one expense category makes up the amount reported in the item, the description must still include both the name of the expense category and the dollar amount applicable to it. The itemization must include a clear and understandable description of the type of expense and the dollar amount for each category of expense. Do not abbreviate the name of the expense category. Do not include expense categories such as "other", "miscellaneous", "residual", "allocated amount" or other nonspecific expense category. If necessary, maintain in the documentation file (and properly cross-reference) an additional sheet for such itemizations.

Example: Other ... (Provide description in Explanation Box)...	\$2,420
Staff travel and training costs	\$2,023
Staff continuing education costs for licensure	\$ 397

STANDARDS FOR AN ACCEPTABLE COST REPORT:

Each submitted cost report must:

1. be completed in accordance with the cost report instructions and reimbursement methodology rules;
2. be completed for the correct cost-reporting period (i.e., the portion of FFY during which the provider delivered Medicaid services under the SHARS program);
3. be completed using the accrual, modified accrual or cash basis method of accounting for governmental entities;
4. reconcile to your trial balance and general ledger accounts;
5. report dollar amounts properly rounded to the nearest dollar and report statistical information to two decimal places;
6. calculate all percentages used in calculations to at least two decimal places;
7. have complete edit explanations with sufficient detail to explain all variances;
8. be submitted in the SHARS web-based cost report system; and
9. have signed, notarized, original certification pages submitted to and received by HHSC on or before posted due dates.

RETURN OF UNACCEPTABLE COST REPORTS

Cost reports that are not in compliance with the above standards will be returned/rejected. The provider will be required to ensure proper completion and resubmission. Failure to timely resubmit a cost report completed in accordance with all applicable rules and instructions will result in the placement of a vendor hold until the requested information has been received by HHSC.

AMENDED COST REPORTS

Provider-initiated amendments and/or adjustments to a closed cost report must be requested in writing. Written requests may be sent to: ra_shars@hhsc.state.tx.us

ACCOUNTING METHOD

All information submitted on cost reports must be based upon the accrual, modified accrual or cash basis method of accounting for governmental entities.

Cost reporting by providers should be consistent with generally accepted accounting principles (GAAP), which are those principles approved by the American Institute of Certified Public Accountants (AICPA).

ALLOWABLE AND UNALLOWABLE COSTS

Only adequately documented, reasonable and necessary allowable program costs incurred or accrued during the cost-reporting period are to be included in the cost report. These costs must be reported in accordance with this program's published reimbursement methodology. Cost is allowed to the extent that it is incurred to support services provided pursuant to an IEP by a Medicaid qualified provider.

COST REPORT CERTIFICATION

Providers must certify the accuracy of the cost report submitted to HHSC. Providers may be liable for civil and/or criminal penalties if the cost 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 cost-reporting requirements.

DIRECT COSTING

Direct costing must be used unless otherwise stated in these instructions. Direct costing means that costs incurred for the benefit, or directly attributable to, a specific service must be charged directly to that particular service. Costs related to each direct medical service must be direct costed. For example, all supplies/materials and other direct costs must relate directly to the specific service and cannot be allocated. Employee payroll taxes and benefits/insurance costs must be direct costed to the individual employee and cannot be allocated. The only costs that can be allocated are specialized transportation services costs.

COST ALLOCATION METHODS

Cost is allocated using statistics that have been approved by CMS to facilitate the identification of cost associated with Medicaid. There are four key allocation methods used in this cost report: (1) an allocation method to identify the cost of medical services irrespective of payer and administrative cost; (2) a method for allocating direct medical services costs to the Texas Medicaid program; (3) a method for allocating transportation costs that cannot be direct costed to specialized transportation services; and (4) a method for allocating specialized transportation based on the one-way trip ratio.

- The first allocation method is the direct services time study percentage, which reports the amount of time related to all medical services and Medicaid administrative claiming. HHSC provides this number to providers based on a statewide time study.
- The second allocation method is the ratio of Medicaid covered students with medical IEPs to all students with medical IEPs. Medical IEPs refers to students with IEPs that document the need for a direct medical service.
$$\text{IEP Ratio} = \frac{\text{The total number of Medicaid students with IEPs requiring medical services}}{\text{The total number of students with IEPs requiring medical services}}$$
- The third allocation method used in this cost report is for transportation costs that cannot be direct costed to specialized transportation services, e.g., fuel, insurance, and/or bus mechanic costs. If costs cannot be direct costed to specialized transportation services, it is acceptable to allocate the costs to specialized transportation services based on the number of specialized transportation vehicles divided by the total number of transportation vehicles.
- The fourth allocation method is the ratio of one-way specialized transportation trips provided on a day when medical services pursuant to an IEP were provided divided by the total number of one-way specialized transportation trips.
$$\text{One-way trip ratio} = \frac{\text{total one-way trips for Medicaid students with IEPs requiring specialized transportation services}}{\text{Total one-way trips for all students with IEPs requiring specialized transportation services}}$$

RECORDKEEPING

Providers must maintain records that are accurate and sufficiently detailed to substantiate the legal, financial, and statistical information reported on the cost report. These records must demonstrate the necessity, reasonableness, and relationship of the costs (e.g., personnel, supplies, and services) to the provision of services. These records include, but are not limited to, all accounting ledgers, journals, invoices, purchase orders, vouchers, canceled checks, timecards, payrolls, mileage logs, flight logs, loan documents, insurance policies, asset records, inventory records, organizational charts, time studies, functional job descriptions, verification of credentials, work papers used in the preparation of the cost report, trial balances, and cost allocation spreadsheets.

HHSC requires that the provider maintain cost report work papers for a minimum period of seven years or until audited whichever is longer following the end of each cost-reporting period.

Adequate documentation is often not maintained by providers to support costs associated with seminars/conferences and out-of-state travel. Adequate documentation for seminars/conferences includes, at a minimum, a program brochure describing the seminar or a conference program with a description of the workshop attended. The documentation must provide a description clearly demonstrating that the seminar or workshop provided training pertaining to client care-related services or quality assurance.

FAILURE TO MAINTAIN RECORDS

Failure to maintain records in a form that is in compliance with HHSC requirements and that will support the information submitted on the cost report may result in the cost report being returned as unacceptable or the cost being removed as unallowable from the cost report.

ACCESS TO RECORDS

Each provider or its designated agent(s) must allow access to all records necessary to verify information submitted on the cost report. This requirement includes records pertaining to related-party transactions and other activities in which the provider is engaged. Failure to provide upon request or to allow inspection of pertinent records by HHSC may result in the return of the cost report as unacceptable or placement of a vendor hold until access is provided.

RELATED PARTY TRANSACTIONS

Each provider or its designated agent(s) must report all related party transactions at "true costs" on the cost report.

FIELD AUDIT AND DESK REVIEW OF COST REPORTS

A desk review will be performed on each cost report. The desk review ensures that all financial and statistical information submitted on the cost report conforms to all applicable rules and instructions. Cost reports not completed according to applicable rules and instructions are considered unacceptable cost reports. A field audit may be performed on select cost reports.

If issues arise during the desk review, a field audit will be scheduled to ensure the fiscal integrity of the program. Field audits are conducted in a manner consistent with generally accepted auditing standards (GAAS), which are included in Government Auditing Standards: Standards for Audit of Governmental Organizations, Programs, Activities, and Functions. These standards are approved by AICPA and are issued by the Comptroller General of the United States.

NOTIFICATION OF EXCLUSIONS AND ADJUSTMENTS

HHSC notifies the provider by regular mail of any exclusions and/or adjustments to line items of the cost report. The notification is sent within 15 working days after the cost report is finalized. HHSC furnishes providers with written reports of the results of field audits. Field audit reports are mailed within 30 days of the final exit interview.

REVIEWS OF EXCLUSIONS AND ADJUSTMENTS

A provider that disagrees with adjustments made during the audit desk review or field audit must write the Director of HHSC Rate Analysis at the address on Page 2 of these instructions within 30 days of the date of the notification of exclusions or adjustments to request an informal review. Requests for informal review received after 30 days from the date of the notification of exclusions and adjustments will not be accepted.

COMMON COST REPORTING ERRORS

The following is a list of some of the more common errors found on cost reports. These errors, as well as others, can be avoided by carefully following the cost report instructions and reimbursement methodology concerning allowable and unallowable expenses. There are edits in the web-based cost-reporting system that will prompt providers if any of these errors occur.

1. Items are left blank that require an entry; for example, no hours reported for an employee type for which salaries are reported.
2. "Yes" or "No" boxes are not completed.
3. Monetary amounts are not rounded to whole numbers.
4. Detail not provided for items requiring "Provide detailed description in explanation box."
5. Math errors.
6. Negative numbers are reported.
7. Combining of costs that should be separately reported; for example, the salary costs incurred for therapists and therapist assistants are all reported on the same line.
8. Misclassification; for example, the expense for staff travel costs included on the line for "Supplies & Materials" rather than on the "Other" line or salaries and wages for therapy assistants reported on the line for therapists rather than on the line for therapy assistants.
9. Transfer errors; for example, amounts reported on Schedule A for depreciation do not match the amounts reported on the depreciation expense line items.

Common Errors Regarding Unallowable Costs:

- A. Expenses reported for activities not related to services.
- B. Personal expenses reported for items such as in-town lunches, travel expenses not related to employee business travel, and personal use of company cellular phone.
- C. Expensing capital expenditures (rather than properly depreciating them) for items such as specialized transportation services vehicles.
- D. Payroll taxes for FICA and Medicare are not equal to 7.65% of the total reported salaries and no reconciliation explanation is provided for any salaries in excess of FICA and Medicare limit or tax deferred benefit plans.
- E. Depreciation costs overstated because of:
 - Accelerated method used instead of straight-line method and

- Useful lives being assigned to assets that are shorter than those required for cost-reporting purposes.

DEFINITIONS

NOTE: For terms not defined in this section, refer to the **SPECIFIC INSTRUCTIONS section.**

ALLOCATION - method of distributing costs on a prorata basis. For more information, see COST ALLOCATION METHODS in the General Instructions section.

ALLOWABLE COSTS - identified as expenses that are reasonable and necessary to provide care to clients and are consistent with federal and state laws and regulations. For more information, see ALLOWABLE AND UNALLOWABLE COSTS in the General Instructions section.

CONTRACTED STAFF - personnel for whom the provider is not responsible for the payment of payroll taxes (such as FICA, FUTA, and TUCA). Contracted staff refers to those persons performing functions routinely performed by employees. Contracted staff does not include consultants; however, includes temporaries, substitutes, and contract labor.

DEPRECIATION EXPENSE - the periodic reduction of the value of an asset over its useful life or the recovery of the asset's cost over the useful life of the asset. For additional information, see SPECIFIC INSTRUCTIONS for Schedule A.

DIRECT COST - allowable expenses incurred by the provider specifically designed to provide services for this program. Direct costs include direct care salary-related costs (i.e., salaries, payroll taxes, employee benefits, and workers compensation costs) and direct care other costs [e.g., supplies/materials, staff travel/training, staff continuing education for licensure, etc.]. See definition for DIRECT COSTING and the GENERAL INSTRUCTIONS for DIRECT COSTING. Direct cost must exclude medical costs that support administrative and/or educational activities.

DIRECT MEDICAL SERVICES - include counseling services, psychological services (including assessments), physician services, audiology, physical therapy, occupational therapy, speech-language pathology services, nursing services, personal care, and transportation services.

EMPLOYEE BENEFITS - include employer-paid health, life, or disability insurance premiums, or employer-paid child day care for children of employees paid as employee benefits on behalf of your staff. Self-insurance paid claims should be properly direct costed and reported as employee benefits. Workers' compensation costs should also be reported as employee benefits.

Workers' compensation costs refer to expenses associated with employee on-the-job injuries. Costs must be reported with amounts accrued for premiums, modifiers, and surcharges. Costs must be reported net of any refunds and discounts actually received or settlements paid during the same cost-reporting period. The premiums are accrued, while the refunds, discounts, or settlements are reported on a cash basis. Litigation expenses related to workers' compensation lawsuits are not allowable costs. Costs related to self-insurance are allowable on a claims-paid basis and are to be reported on a cash basis. Self-insurance is a means whereby a provider undertakes the risk to protect itself against anticipated liabilities by providing funds in an amount equivalent to liquidate those liabilities. Self-insurance can also be described as being uninsured. Contributions to self-insurance funds that do not represent payments based on current liabilities are unallowable costs.

INDIRECT COST – indirect cost for school-based services is derived by applying the provider-specific cognizant agency unrestricted indirect cost rate (UICR). This rate is made available to each provider by the Texas Education Agency (TEA). The provider-specific cognizant agency unrestricted indirect cost rate (UICR) is reported on the cost report, and each district must verify the accuracy of its provider-specific UICR.

IEP – Individualized Education Program

NET EXPENSES - gross expenses less any purchase discounts or returns and purchase allowances.

NOT ONLY SPECIALIZED TRANSPORTATION – reflects transportation employees/contractors whose servicing and/or driving duties float between Specially Adapted Vehicles and regular transportation vehicles.

ONLY SPECIALIZED TRANSPORTATION – reflects transportation employees/contractors whose primary transportation duties are to service and/or drive a Specially Adapted Vehicle.

PROVIDER - the school district or charter school that has a Medicaid enrollment agreement for providing services under the Texas Medicaid SHARS Program.

PURCHASE DISCOUNTS - discounts such as reductions in purchase prices resulting from prompt payment or quantity purchases, including trade, quantity, and cash discounts. Trade discounts result from the type of purchaser the contracted provider is (i.e., consumer, retailer, or wholesaler). Quantity discounts result from quantity purchasing. Cash discounts are reductions in purchase prices resulting from prompt payment. Reported costs must be reduced by these discounts prior to reporting the costs on the cost report.

PURCHASE RETURNS AND ALLOWANCES - reductions in expenses resulting from returned merchandise or merchandise that is damaged, lost, or incorrectly billed. Reported expenses must be reduced by these returns and allowances prior to reporting the costs on the cost report.

REIMBURSEMENT METHODOLOGY - rules (Title 1 of the Texas Administrative Code, Part 15, Chapter 355, SubChapter J, Division 23, Rule 8443) by which HHSC determines district-specific interim rates for SHARS services.

SPECIALLY ADAPTED VEHICLE – A vehicle that has been physically modified (e.g. addition of a wheelchair lift, addition of seatbelts or harnesses, addition of child protective seating, or addition of air conditioning to accommodate students whose IEP includes the documented need for the special adaptation)

VENDOR HOLD - HHSC may withhold payments from providers in certain specific situations. A vendor hold warning letter will be sent to the school district prior to placement on vendor hold on the provider’s payments.

WORKERS' COMPENSATION COSTS - for cost-reporting purposes, the actual costs paid by the provider during the reporting period related to employee on-the-job injuries (such as commercial insurance premiums or the medical bills paid on behalf of an injured employee) are allowable.

SPECIFIC INSTRUCTIONS

IN ORDER TO PROPERLY COMPLETE THE COST REPORT, THE PREPARER SHOULD:

1. Read these instructions;
2. Read the Reimbursement Methodology Rules for SHARS at Title 1 of the Texas Administrative Code, Part 15, Chapter 355, SubChapter J, Division 23, Rule 8443;
3. Have attended SHARS Cost Report training sponsored by HHSC;
4. Create a comprehensive reconciliation worksheet to serve as a crosswalk between your accounting records and the cost report and vice versa; and
5. Create worksheets to explain adjustments to year-end balances due to the application of cost-reporting rules and instructions.

If you do not have item 2, you may obtain these rules from the HHSC Rate Analysis Website at <http://www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml> or contact your SHARS Rate Analyst.

COVER PAGE

9-DIGIT Texas Provider Identifier (TPI)

Enter your **9-digit SHARS TPI number**.

If, after looking at your recent payment information, correspondence from HHSC or its Medicaid contractor (Texas Medicaid & Healthcare Partnership - TMHP), and/or your provider enrollment agreement with the Texas Medicaid Program, you do not know your correct 9-digit SHARS TPI, please contact your SHARS Rate Analyst listed on the cover of these instructions. This information will be provided on the cost report and providers are requested to verify the accuracy of this information.

9-DIGIT National Provider Identifier (NPI)

Enter your 9-digit SHARS NPI number. If you do not know your correct 9-digit SHARS NPI, please contact your SHARS Rate Analyst listed on the cover of these instructions. This information should be provided on the cost report if the provider has attested to its NPI. Providers are requested to verify the accuracy of this information.

SHARS PROVIDER IDENTIFICATION

Enter the name of the school district or charter school and its physical address. Be sure to report the appropriate 9-digit zip code for each address. If you do not know the correct 9-digit zip code(s), please contact your local post office or research "zip codes" on the Internet.

BUSINESS MANAGER/FINANCIAL DIRECTOR

Each provider must complete the requested information regarding the business manager or financial director for the school district. The business manager or financial director should be able to answer questions about the contents of your cost report that arise during the cost report edit process and the desk review or field audit process.

REPORT PREPARER IDENTIFICATION

Each provider must complete the requested information regarding the preparer of the cost report. The **preparer** of the cost report is the person who actually prepared the cost report, whether the preparer is an employee of the school district or is contracted to complete the cost report. The preparer should have attended the HHSC-sponsored Cost Report Training for the SHARS Cost Report. If more than one person prepared the cost report, a Cost Report Certification page must be submitted for each preparer (and each preparer should have attended the training for the SHARS Cost Report). The preparer must also sign, before a notary, the COST REPORT CERTIFICATION page.

Accounting records that support this cost report are located at (street, city, state, and zip)

Report the address where the provider's accounting records and supporting documentation used to prepare this cost report are maintained. This should be the address at which a field audit of these records can be conducted. These records do not refer solely to the work papers used by your CPA or other outside cost report preparer. (See also the RECORDKEEPING section of the General Instructions.)

GENERAL AND STATISTICAL

9-Digit TPI Number:

Enter your 9-digit SHARS Texas Provider Identifier (TPI) number. This information will be provided on the cost report and providers are requested to verify the accuracy of this information.

9-Digit NPI Number:

Enter your 9-digit SHARS National Provider Identifier (NPI) number. This information should be provided on the cost report if the provider has attested to its NPI. Providers are requested to verify the accuracy of this information.

6-Digit County District Number:

Enter your 3-digit county number plus your 3-digit district number, resulting in your 6-digit county district number. This information will be provided on the cost report and providers are requested to verify the accuracy of this information.

Texas County Codes:

Texas county codes are listed on the last page of these instructions. Be sure to use the listing on the last page of these instructions and NOT the codes used for reporting to the Texas Workforce Commission. This information will be provided on the cost report and providers are requested to verify the accuracy of this information.

Texas County Code in Which District is Located - Report the 3-digit county code for the Texas county in which the provider is located.

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 cost report are located.

Reporting Period Beginning and Ending Dates:

In accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 355, SubChapter J, Division 23, Rule 8443, each School Health and Related Services (SHARS) provider will complete an annual cost report for all SHARS services delivered during the previous federal fiscal year covering October 1 through September 30.

SHARS providers who are members of a cooperative or shared services arrangement must each submit a separate SHARS Cost Report.

Is the Reporting Period less than a full year?

If your cost-reporting period does not consist of a full year, report the beginning and ending dates for your reporting period and provide an explanation, in the Explanation Box, as to why it is less than 12 months.

STATISTICAL INFORMATION

Unrestricted Indirect Cost Rate

Unrestricted Indirect Cost Rate (percentage)

Verify the accuracy of the TEA-calculated unrestricted indirect cost rate (UICR) for the cost-reporting period reported on the cost report.

Direct Medical Services Percentage Derived from Approved Time Study Time Study - Activity Percentage for SHARS

This amount will be provided by HHSC.

Individualized Education Program (IEP) Ratio

The IEP Ratio is used in the calculation of Medicaid-allowable costs for direct medical services.

Total Medicaid IEP Students

Report the unduplicated count of IEPs for Medicaid-eligible students that require one or more direct medical services covered under the Medicaid SHARS Program during the cost-reporting period.

Total IEP Students

Report the unduplicated count of all IEPs for all students (i.e., Medicaid and non-Medicaid) that require one or more direct medical services covered under the Medicaid SHARS Program during the cost-reporting period.

See "Cost Allocation Methods" on page 5.

Specialized Transportation for IEP Students: One-Way Trips

Transportation services are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom the services are medically necessary.

Total Medicaid IEP Students - Allowable Trips

Report the total number of specialized transportation one-way trips during the cost-reporting period. Medicaid reimburses on the basis of one-way trips on days when medical services were delivered pursuant to an IEP.

Total IEP Student Trips

Report the total number of specialized transportation one-way trips during the cost-reporting period for all students (i.e., Medicaid and non-Medicaid) whose IEPs require specialized transportation services.

DIRECT MEDICAL SERVICES

Direct Medical Services include the following services:

- Audiology and Hearing, including evaluations and therapy sessions
- Physician Services
- Occupational Therapy, including evaluations and therapy sessions
- Physical Therapy, including evaluations and therapy sessions
- Psychological Services, including assessments and therapy sessions
- Speech and Language Services, including evaluations and therapy sessions,
- Nursing Services, including routine medication administration services
- Counseling Services
- Personal Care Services

The following eight pages are copies of the actual CMS-approved Texas Medicaid State Plan pages that include the description of the services and the personnel that can deliver the services.

The purpose of the Texas SHARS Cost Report is to capture Medicaid-allowable costs for the CMS-approved personnel delivering direct medical services in accordance with the CMS-approved Texas Medicaid State Plan, in addition to capturing Medicaid-allowable costs associated with specialized transportation services.

DIRECT MEDICAL SERVICES: AUDIOLOGY & HEARING

The definition of audiology and hearing according to the Texas Medicaid State Plan approved by the Centers for Medicare & Medicaid Services (CMS) is as follows.

Audiology and Hearing Services

Definition:

Audiology and hearing services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom services are medically necessary.

Services:

Audiology Services:

Medically necessary audiology services include but are not limited to:

1. Identification of children with hearing loss;
2. Determination of the range, nature and degree of hearing loss, including the referral for medical or other professional attention for the amelioration of hearing;
3. Provision of amelioration activities, such as language amelioration, auditory training, speech reading (lip reading), hearing evaluation and speech conversation;
4. Determination of the child's need for group and individual amplification; and
5. Hearing aid services.

Hearing Services:

Hearing aid and audiometric evaluation services for Medicaid clients younger than 21 years of age are reimbursed to willing and qualified Medicaid providers, meeting the qualifications described below.

Audiology and hearing services may be provided in an individual or group setting.

Providers:

Audiology and hearing services must be provided by a qualified audiologist who meets the requirements of 42 CFR § 440.110(c) (3) and in accordance with applicable state and federal law or regulation.

Services may be provided by:

- A qualified audiologist licensed by the state to furnish audiologist services; or
- A qualified audiology assistant licensed by the state, when the services are provided in a facility setting (such as a comprehensive outpatient rehabilitation facility, an outpatient rehabilitation facility, an outpatient hospital, an inpatient hospital, or a school) and when the assistant is acting under the supervision or direction of a qualified audiologist in accordance with 42 CFR § 440.110 and other applicable state and federal law.

Place of Service:

Audiology and hearing services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.

DIRECT MEDICAL SERVICES: PHYSICIAN SERVICES

The definition of physician services according to the Texas Medicaid State Plan approved by CMS is as follows.

Physician Services

Definition:

Physician services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom the service is medically necessary.

Services:

EPSDT medically necessary services are health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate any disability and chronic conditions. These services include but are not limited to:

1. Physician services; and
2. Diagnostic and evaluation services to determine a child's medically related condition that results in the child's need for Medicaid services.

Physician services may be provided only in an individual setting.

Providers:

Physician services must be provided by a qualified physician who meets the requirements of, and in accordance with, 42 CFR § 440.50(a) and other applicable state and federal law or regulation.

Place of Service:

Physician services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.

DIRECT MEDICAL SERVICES: OCCUPATIONAL THERAPY

The definition of occupational therapy according to the Texas Medicaid State Plan approved by CMS is as follows.

Occupational Therapy

Definition:

Occupational therapy services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom the services are medically necessary.

Services:

Occupational therapy services must be prescribed by a physician. These services include any necessary supplies and equipment utilized during the therapy session.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate any disability and chronic conditions. These services include but are not limited to:

1. Identification of children with occupational therapy needs;
2. Evaluation for the purpose of determining the nature, extent and degree of the need for occupational therapy services;
3. Improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation;
4. Improving ability to perform tasks for independent functioning when functions are impaired or lost; and
5. Preventing, through early intervention, initial or further impairment or loss of function.

Occupational therapy services may be provided in an individual or group setting.

Providers:

Occupational therapy services must be provided by a qualified occupational therapist who meets the requirements of 42 CFR §440.110(b) and in accordance with applicable state and federal law or regulation.

Services may be provided by:

- A qualified occupational therapist licensed by the state to furnish occupational therapy services; or
- A certified occupational therapy assistant (COTA) when the services are provided in a facility setting (including a comprehensive outpatient rehabilitation facility, an outpatient rehabilitation facility, an outpatient hospital, an inpatient hospital, or a school) and when the assistant is acting under the supervision or direction of a qualified occupational therapist in accordance with 42 CFR § 440.110 and other applicable state and federal law.

Place of Service:

Occupational therapy services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.

DIRECT MEDICAL SERVICES: PHYSICAL THERAPY

The definition of physical therapy according to the Texas Medicaid State Plan approved by CMS is as follows.

Physical Therapy

Definition:

Physical therapy services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom services are medically necessary.

Services:

Physical therapy services must be prescribed by a physician. These services include any necessary supplies and equipment utilized during the therapy session.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct or ameliorate any disability and chronic conditions. These services include but are not limited to:

1. Identification of children with physical therapy needs;
2. Evaluation for the purpose of determining the nature, extent and degree of the need for physical therapy services;
3. Physical therapy services provided for the purpose of preventing or alleviating movement dysfunction and related functional problems; and
4. Obtaining, interpreting, and integrating information appropriate to program planning.

Physical therapy services may be provided in an individual or group setting.

Providers:

Physical therapy services must be provided by a qualified physical therapist who meets the requirements of 42 CFR § 440.110(a) and in accordance with applicable state and federal law or regulation.

Services may be provided by:

- a qualified physical therapist licensed by the state to furnish physical therapy services; or
- a licensed physical therapy assistant (LPTA) when the services are provided in a facility setting (including a comprehensive outpatient rehabilitation facility, an outpatient rehabilitation facility, an outpatient hospital, an inpatient hospital, or a school) and when the assistant is acting under the supervision or direction of a qualified physical therapist in accordance with 42 CFR § 440.110 and other applicable state and federal law.

Place of Service:

Physical therapy services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.

DIRECT MEDICAL SERVICES: SPEECH AND LANGUAGE SERVICES

The definition of speech and language according to the Texas State Medicaid State Plan approved by CMS is as follows.

Speech and Language Services

Definition:

Speech and language services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom services are medically necessary.

Services:

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct or ameliorate any disability and chronic conditions. These services include but are not limited to:

1. Identification of children with speech or language disorders;
2. Diagnosis and appraisal of specific speech or language disorders;
3. Referral for medical or other professional attention necessary for the habilitation of speech or language disorders; and
4. Provision of speech or language services for the habilitation or prevention of communicative disorders.

Speech and language services must be prescribed by a physician. In a school setting, speech and language services may be prescribed by either a physician or by another licensed practitioner of the healing arts within the scope of his or her practice under state law in accordance with 42 CFR § 440.110(c).

Speech and language therapy services may be provided in an individual or group setting.

Providers:

Speech and language services must be provided by:

- A qualified speech/language pathologist (SLP) who meets the requirements of, and in accordance with, 42 CFR § 440.110(c), and other applicable state and federal law or regulation;
- American Speech-Language-Hearing Association (ASHA) certified SLP with Texas license and ASHA-equivalent SLP (i.e., SLP with master's degree and Texas license) when the services are provided in a school setting. (Pending equivalency ruling by Texas Attorney General's opinion.);
- A qualified assistant in SLP licensed by the state, when the services are provided in a facility setting (including a comprehensive outpatient rehabilitation facility, an outpatient rehabilitation facility, an outpatient hospital, an inpatient hospital, or a school) and when the assistant is acting under the supervision or direction of a qualified SLP in accordance with 42 CFR § 440.110 and other applicable state and federal law; or
- A provider with a state education agency certification in speech language pathology, a licensed SLP intern, and a grandfathered SLP (has a Texas license and no master's degree) when the services are provided in a school setting and when these providers are acting under the supervision or direction of a qualified SLP in accordance with 42 CFR § 440.110 and other applicable state or federal law.

Place of Service:

Speech and language services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.

DIRECT MEDICAL SERVICES: NURSING SERVICES

The definition of nursing according to the Texas Medicaid State Plan approved by CMS is as follows.

Nursing Services

Definition:

Nursing services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom the service is medically necessary.

Services:

Nursing services are defined as the promotion of health, prevention of illness, and the care of ill, disabled and dying people through the provision of services essential to the maintenance and restoration of health.

Nursing services may be provided in an individual or group setting.

Providers:

Nursing services must be provided by a qualified nurse who meets qualification requirements of, and in accordance with, 42 CFR § 440.60 and other applicable state and federal law or regulation, including nursing services delivered by advanced practice nurses (APNs) including nurse practitioners (NPs) and clinical nurse specialists (CNSs), registered nurses (RNs), licensed vocational nurses (LVNs), licensed practical nurses (LPNs).

Nursing services provided on a restorative basis under 42 CFR § 440.130(d), including services delegated in accordance with the Texas Board of Nurse Examiners to individuals who have received appropriate training from a RN.

Place of Service:

Nursing services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.

DIRECT MEDICAL SERVICES: COUNSELING SERVICES

The definition of counseling services according to the Texas Medicaid State Plan approved by CMS is as follows.

Counseling Services

Definition:

Counseling services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and for whom services are medically necessary.

Services:

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct or ameliorate any disability and chronic conditions. These services are intended for the exclusive benefit of the Medicaid eligible child and include but are not limited to:

1. Services provided to assist the child and/or parents in understanding the nature of the child's disability;
2. Services provided to assist the child and/or parents in understanding the special needs of the child;
3. Services provided to assist the child and/or parents in understanding the child's development;
4. Health and behavior interventions to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems.
5. Counseling services as identified in Appendix 1 to Attachment 3.1-A, Item 6.d. of the state plan; and
6. Assessing needs for specific counseling services.

Counseling services may be provided in an individual or group setting.

Providers:

Counseling services must be provided by a qualified counselor who meets qualification requirements of, in accordance with, 42 CFR § 440.60(a) and other applicable state and federal law or regulation.

Services may be provided by a:

- Licensed Psychologist;
- Licensed Psychiatrist;
- Licensed Clinical Social Worker (LCSW);
- Licensed Marriage and Family Therapist (LMFT);
- Licensed Professional Counselor (LPC); or
- Licensed Specialist in School Psychologist (LSSP) when the services are provided in a school setting.

Place of Service:

Counseling services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.

DIRECT MEDICAL SERVICES: PERSONAL CARE SERVICES

The definition of personal care services according to the Texas Medicaid State Plan approved by CMS is as follows.

Personal Care Services

Definition:

Personal care services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and for whom services are medically necessary.

Services:

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct or ameliorate any defects and chronic conditions. Personal care services are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease. Services must be authorized by a physician in accordance with a plan of treatment or (at the State's option) in accordance with a service plan approved by the State.

Medically necessary services include but are not limited to clients with a physical, cognitive, or behavioral limitation related to his or her disability or chronic health condition that inhibits the client's ability to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs) or related health functions.

Personal care services may be provided in an individual or group setting.

Providers:

Personal care services must be provided by a qualified provider in accordance with 42 CFR § 440.167, who is 18 years or older and has been trained to provide the personal care services required by the client, e.g., bus monitor/aide when provided on a specially adapted school bus, special education teacher and special education teacher's aide.

Place of Service:

Personal care services are furnished in a home, and at the State's option, in another location, e.g., school.

DIRECT MEDICAL SERVICES

STAFF EXPENSES

PAID HOURS

Report total paid hours for all services employed or contracted by you that delivered any direct medical services to Medicaid and/or non-Medicaid clients. Report total paid hours using two decimal places, even if the two decimal places are 00's. Include overtime, travel time, documentation time, training time, staff meeting time, paid vacation time, and paid sick leave time relating to the salaries and wages reported. If an employee or contracted staff only provides supervisory services and does not deliver any direct medical services at all to clients, that person's paid hours and costs should not be reported on the cost report.

SALARIES & WAGES [From Worksheet B]

Report salaries and wages for all services employed by you and for whom you are required to make FICA contributions. Salaries and wages include overtime, cash bonuses, and any cash incentives paid from which payroll taxes are (or should be) deducted. If an employee or contracted staff only provides supervisory services and does not deliver any direct medical services at all to clients, that person's paid hours and costs should not be reported on the cost report.

CONTRACTED COMPENSATION [From Worksheet B]

Report compensation paid for all services contracted by you who delivered any services to Medicaid and/or non-Medicaid clients. If an employee or contracted staff only provides supervisory services and does not deliver any direct medical services at all to clients, that person's paid hours and costs should not be reported on the cost report.

Employee Benefits [Provide detailed description in explanation box] [From Worksheet B]

Report the **direct costed** employer-paid health, life, or disability insurance premiums or employer-paid child day care for children of employees paid as employee benefits on behalf of your staff. Self-insurance paid claims should be properly direct costed and reported as employee benefits, as well as workers' compensation costs. See "DEFINITIONS" for additional information regarding workers' compensation costs.

In the Explanation Box, give a description of the each type of benefits/insurance and the associated cost for each.

Employer Retirement Contribution [From Worksheet B]

Report the **direct costed** employer retirement contributions for the employees whose salaries and wages are reported above.

Employer FICA Payroll Taxes [From Worksheet B]

Report the **direct costed** employer-paid FICA contributions for the employees whose salaries and wages are reported above.

Employer Medicare Payroll Taxes [From Worksheet B]

Report the **direct costed** employer-paid Medicare contributions for the employees whose salaries and wages are reported above.

State Unemployment Payroll Taxes [From Worksheet B]

Report the **direct costed** employer-paid Texas Unemployment Compensation Act (TUCA) contributions for the employees whose salaries and wages are reported above. If you are not required to pay quarterly taxes to the Texas Workforce Commission (TWC) for unemployment, you need to submit documentation from TWC that you are a Reimbursing Employer [e.g., TWC Form C-66R (0891) "Notice of Maximum Potential Charge - Reimbursing Employer" or a copy of a quarterly TWC report or notification letter from TWC] or that you are exempt from the payment of unemployment coverage. If you are a Reimbursing Employer, your payments for employees whose salaries are reported above should be reported as "Unemployment Compensation (Reimbursing Employer)".

Federal Unemployment Payroll Taxes [From Worksheet B]

Report the **direct costed** employer-paid Federal Unemployment Taxes Act (FUTA) contributions for the employees whose salaries and wages are reported above.

Unemployment Compensation (Reimbursing Employer) [From Worksheet B]

See also "State Unemployment Payroll Taxes." If you are a Reimbursing Employer, submit the above-requested documentation from TWC and report the actual amount of unemployment compensation paid for any employee whose salaries and wages are reported above.

DIRECT MEDICAL OTHER

Supplies & Materials [Provide detailed description in explanation box]

Report **direct costed** supplies and materials related to all services.

Do not report supplies and material that support administrative services such as copier services and copy paper and copier supplies.

In the Explanation Box, give a description of each type of other direct medical costs and the dollar amount for each.

Other Direct Costs for all Direct Medical Services are listed in Appendix A.

Appendix A is an all-inclusive list of Medicaid-allowable costs for direct medical services. The list provided in appendix A includes the only approved materials and supplies. Any request for additional items not included will require CMS approval.

Staff travel costs to provide direct medical services to recipient (e.g., travel between medical services sites/campuses). Allowable staff travel expenditures include mileage reimbursements, gasoline/oil allowances/reimbursements, cab fare, bus fare, hotel, and other travel reimbursements paid to staff. Overnight travel expenditures should be infrequent. Do not include client transportation costs.

Direct medical services depreciation [See Schedule A-1 for details].

Direct medical services required continuing education is allowable for professional staff for licensure and/or certification required to perform direct medical services. Allowable expenditures include training and continuing education seminars, travel and other staff cost to maintain professional licensure and/or certification. Allowable staff travel expenditures include mileage reimbursements, gasoline/oil allowances/reimbursements, cab fare, bus fare, hotel, air fare and other travel reimbursements paid to staff.

Education and/or training costs are not allowable for staff pursuing licensure and/or certification as a new profession. For example, education and training cost for a teacher's aide to become a certified home health aide are not allowable.

REDUCTIONS

Staff Costs Reduction for Federal Funds and Grants [From Worksheet B]

This amount transfers from Worksheet B and includes federal funding for any of the costs reported for all services, with the exception of Medicaid Administrative Claiming (MAC) federal funding for these services. Costs are not reduced by MAC funding, as the "Time Study - Activity Percentage for SHARS" covers the reduction of costs from MAC funding. An example of federal funding to be reported as a reduction to costs is funding through the Individuals with Disabilities Education Act (IDEA). Federal IDEA funding that will reduce costs includes both the actual IDEA payments and the state/local funds used as maintenance of effort (MOE) funding required for the IDEA payments. If any federal funding that will reduce costs requires a percentage match, the state/local funds used for the match must also be reduced

Other [Provide detailed description in explanation box]

Other funding by which costs are reduced would include recovery of costs. For example, if an insurance claim were filed and the insurance company made a payment to the provider, that payment would be considered the recovery of costs and should be reported as a reduction to costs.

REIMBURSABLE COST CALCULATION

This section is automated and requires no entries from providers.

SPECIALIZED TRANSPORTATION SERVICES

The definition of specialized transportation services according to the Texas Medicaid State Plan approved by the Centers for Medicare & Medicaid Services (CMS) is as follows.

Transportation Services in the School Setting

Definition:

Transportation services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom the services are medically necessary.

Services:

Medically necessary transportation services are provided to all Medicaid-eligible children when the Medicaid-eligible children are receiving school-based services (also known as School Health and Related Services (SHARS)) on the same day. Transportation services are provided on a specially adapted school bus to and/or from the location where the school-based service is provided.

Providers:

Transportation services must be provided by a qualified Medicaid provider. Transportation services include direct services personnel, e.g. bus drivers employed by the school districts.

The cost allocation method is the ratio of one way specialized transportation trips provided on a day when medical services pursuant to an IEP were provided divided by the total number of one way specialized transportation trips. One-way trip ratio = (total one-way trips for Medicaid students with IEPs requiring specialized transportation services)/ (Total one-way trips for all students with IEPs requiring specialized transportation services).

STAFF EXPENSES

PAID HOURS

Report total paid hours for all bus drivers, mechanics, and mechanic assistants employed or contracted by you that delivered any specialized transportation services to Medicaid and/or non-Medicaid clients. Report total paid hours using two decimal places, even if the two decimal places are 00's. Include overtime, travel time, documentation time, training time, staff meeting time, paid vacation time, and paid sick leave time relating to the salaries and wages reported. If you are not able to direct cost paid hours, you may allocate the paid hours based on the percentage of specialized transportation vehicles to total transportation vehicles.

SALARIES & WAGES [From Worksheet B]

Report salaries and wages for all bus drivers, mechanics, and mechanic assistants employed by you that delivered any specialized transportation services to Medicaid and/or non-Medicaid clients for whom you are required to make FICA contributions. Salaries and wages include overtime, cash bonuses, and any cash incentives paid from which payroll taxes are (or should be) deducted. If you are not able to direct cost salaries and wages, you may allocate the salaries and wages based on the percentage of specialized transportation vehicles to total transportation vehicles.

CONTRACTED COMPENSATION [From Worksheet B]

Report compensation paid for all bus drivers, mechanics, and mechanic assistants contracted by you who delivered any specialized transportation services to Medicaid and/or non-Medicaid clients. If you are not able to direct cost contracted compensation, you may allocate the contracted compensation based on the percentage of specialized transportation vehicles to total transportation vehicles.

EMPLOYEE BENEFITS [Provide detailed description in explanation box] [From Worksheet B]

Report the **direct costed** employer-paid health, life, or disability insurance premiums, or employer-paid child day care for children of employees paid as employee benefits on behalf of employees whose salaries and wages are reported above. Self-insurance paid claims should be properly direct costed and reported as employee benefits, as well as workers' compensation costs. See "DEFINITIONS" section for additional information on workers' compensation costs.

In the Explanation Box, give a description of the each type of benefits/insurance and the associated cost for each.

Employer Retirement Contribution [From Worksheet B]

Report the **direct costed** employer retirement contributions for employees whose salaries and wages are reported above.

Employer FICA Payroll Taxes [From Worksheet B]

Report the **direct costed** employer-paid FICA contributions for the employees whose salaries and wages are reported above.

Employer Medicare Payroll Taxes [From Worksheet B]

Report the **direct costed** employer-paid Medicare contributions for the employees whose salaries and wages are reported above.

State Unemployment Payroll Taxes [From Worksheet B]

Report the **direct costed** employer-paid Texas Unemployment Compensation Act (TUCA) contributions for the employees whose salaries and wages are reported above. If you are not required to pay quarterly taxes to the Texas Workforce Commission (TWC) for unemployment, you need to submit documentation from TWC that you are a Reimbursing Employer [e.g., TWC Form C-66R (0891) "Notice of Maximum Potential Charge - Reimbursing Employer" or a copy of a quarterly TWC report or notification letter from TWC] or that you are exempt from the payment of unemployment coverage. If you are a Reimbursing Employer, your payments for employees whose salaries are reported above should be reported as "Unemployment Compensation (Reimbursing Employer)".

Federal Unemployment Payroll Taxes [From Worksheet B]

Report the **direct costed** employer-paid Federal Unemployment Taxes Act (FUTA) contributions for the employees whose salaries and wages are reported above.

Unemployment Compensation (Reimbursing Employer) [From Worksheet B]

See also "State Unemployment Payroll Taxes." If you are a Reimbursing Employer, submit the above-requested documentation from TWC and report the actual amount of unemployment compensation paid for any employee whose salaries and wages are reported above.

OTHER DIRECT COSTS

Lease/Rental - Transportation Equipment [From Worksheet C]

Report the lease/rental costs of specialized transportation equipment as indicated. Attach a copy of applicable lease agreements. If a vehicle lease includes both specialized transportation equipment and non-specialized transportation equipment, you may allocate the costs based on the number of leased specialized transportation equipment items divided by the total number of leased transportation equipment items.

Insurance - Transportation Equipment [From Worksheet C]

Report the cost for insurance premiums for specialized transportation vehicles. Costs should be reported with amounts accrued for premiums, modifiers, and surcharges and net of any refunds and discounts actually received or settlements paid during the same cost-reporting. If you are not able to direct cost these insurance costs, you may allocate them based on the number of specialized transportation vehicles divided by the total number of total transportation vehicles.

Maintenance & Repairs - Transportation Equipment [From Worksheet C]

Report repairs and maintenance include non-depreciable tune-ups, oil changes, cleaning, licenses, inspections, and replacement of parts due to normal wear and tear (such as tires, brakes, shocks, and exhaust components) for specialized transportation vehicles. Report maintenance supplies related to specialized transportation vehicles. Major vehicle repairs (such as engine and transmission overhaul and replacement) costing \$5,000 or more must be depreciated and reported as "Depreciation - Transportation Equipment." If you are not able to direct cost maintenance and repair costs, you may allocate them based the number of specialized transportation vehicles divided by the total number of transportation vehicles.

Fuel and Oil - Transportation Equipment [From Worksheet C]

Report gasoline, diesel, other fuel and oil costs for specialized transportation vehicles. If you are not able to direct cost fuel and oil costs, you may allocate them based on the number of specialized transportation vehicles divided by the total number of transportation vehicles.

Contract - Transportation Services [From Worksheet C]

Report costs of contracted specialized transportation services. If you are not able to direct cost contracted specialized transportation services costs, you may allocate them based on the number of specialized transportation vehicles divided by the total number of transportation vehicles.

Contract - Transportation Services Equipment [From Worksheet C]

Report costs of contracted specialized transportation services equipment. If you are not able to direct cost contracted specialized transportation service equipment costs, you may allocate them based on the number of specialized transportation vehicles divided by the total number of transportation vehicles.

Purchases under \$5,000 [From Worksheet C]

Report non-depreciable equipment purchases required to maintain and repair specialized transportation equipment as purchases under \$5,000. If you are not able to direct cost these purchases, you may allocate them based on the number of specialized transportation vehicles divided by the total number of transportation vehicles.

Private Payments to Parents [Provide detailed description in explanation box]

Report any payments made to parents for specialized transportation one-way trips.

Other [Provide detailed description in explanation box] [From Worksheet C]

Report **direct costed** supplies and materials related to specialized transportation services, e.g., purchases directly related to specialized transportation bus drivers, mechanics, and mechanic assistants, including any software and costs to maintain staff licensure/certification.

Depreciation - Transportation Equipment [From Schedule A]

Transfer the amount reported on Schedule A.

REDUCTIONS

Staff Costs Reduction for Federal Funds and Grants [From Worksheet B]

This amount transfers from Worksheet B and includes federal funding for any of the costs reported for specialized transportation services, with the exception of Medicaid Administrative Claiming (MAC) federal funding for these services. Specialized transportation services costs are not reduced by MAC funding. An example of federal funding to be reported as a reduction to costs is funding through the Individuals with Disabilities Education Act (IDEA).

Other [Provide detailed description in explanation box]

Other funding by which costs are reduced would include recovery of costs. For example, if an insurance claim were filed and the insurance company made a payment to the provider, that payment would be considered the recovery of costs and should be reported as a reduction to costs.

REIMBURSABLE COST CALCULATION

This section is automated and requires no entries from providers.

CERTIFICATION PAGES

Certification pages must contain original signatures and original notary stamps/seals. If these pages are not properly completed, the cost report will not be processed until the provider makes the necessary corrections.

COST REPORT CERTIFICATION

This page must be completed and signed by an individual legally responsible for the conduct of the provider such as the authorized agent and/or school district representative, including Chief Financial Officer, Business Officer, Superintendent, or other official. The responsible party's signature must be notarized.

CLAIMED EXPENDITURES

Enter the name of the school district on the line provided. Enter the "To" and "From" dates for the period being reported. Enter the total computable expenditures. Total computable expenditures are those expenditures submitted to the Texas HHSC for State Fiscal Year SHARS direct Medicaid services and must equal the combined totals for each service prior to reductions and reimbursable cost calculation.

This page must be signed by the authorized agent and/or representative of the provider, such as the Chief Financial Officer, Business Officer, Superintendent, or other official. The responsible party's signature must be notarized. The responsible party should read the seven certification statements carefully before signing this page before a notary.

SCHEDULE A-1: DEPRECIATION -- DIRECT MEDICAL SERVICES

Depreciation is the periodic reduction of the value of an asset over its useful life or the recovery of the asset's cost over the useful life of the asset. (Please note this is not market value).

Allowable depreciation expense for direct medical services includes only pure straight-line depreciation. No accelerated or additional first-year depreciation is allowable. Any single item purchased during the cost-reporting period costing less than \$5,000 must be expensed and reported accordingly. Depreciation for depreciable items must be calculated using Schedule A-1 and then transferred to the appropriate line item of the cost report.

Required detail must be provided for each depreciable asset and each depreciable asset must be assigned a correct estimated useful life.

It is acceptable to submit a detailed depreciation printout and cross-reference it to Schedule A if the following requirements are met: 1) the attachment must list each item individually, 2) the attachment must list items by proper classification, month/year placed in service, years of useful life, the historical cost, prior period accumulated depreciation and the depreciation for the reporting period.

COMPLETION OF COLUMNS A THROUGH F

COLUMN A (Description of Asset) - describe each individual asset. Do not combine items under generic descriptions such as "various", "additions" or "equipment". Do not combine items by year purchased (e.g., "2003 buses", "2006 buses", etc.) Be specific in providing the description of each depreciable item. Submit and properly cross-reference additional pages if necessary.

COLUMN B (Month/Year Placed in Service) - enter the month and year the asset was placed into service. Do not use "various".

COLUMN C (Years of Useful Life) - enter the estimated useful life of the asset. HHSC requires the following estimated useful lives to be used at a minimum:

Audiometer	10 years
Basins (emesis, water)	7 years
Battery charger	5 years
Blood pressure device, electronic	6 years
Cameras.....	5 years
Chart rack.....	20 years
Chart recorder	10 years
Defibrillator.....	5 years
Dynamometer, hand.....	10 years
Drapery tracks	10 years
Electronic suction unit (aspirator)	10 years
FM amplification systems or other assistive listening devices....	10 years
Folding partitioners.....	10 years
Nebulizer	10 years
Ophthalmoscope	7 years

Optical readers.....	5 years
Otoscope	7 years
Physician's scale with height rod and balance	10 years
Refrigerator for medicine.....	10 years
Sanitizer	10 years
Scoliometer.....	10 years
Sphygmomanometer.....	10 years
Stethoscope	5 years
Table, examining	15 years
Technology devices (computer terminals, word processors, printers)	5 years
Technology devices (computer software).....	3 years
Thermometer, electric.....	5 years
Tympanometer	10 years
Ultrasonic cleaner	10 years
Wheelchair.....	5 years

All Other Assets

Minimum useful lives must be consistent with "Estimated Useful Lives of Depreciable Hospital Assets", published by the American Hospital Association (AHA) (Item Number - 061170). Copies of this publication may be obtained by contacting American Hospital Publishing, Inc., Phone: 800-242-2626, Mailing Address: AHPI, Books Division, 737 North Michigan Avenue, Chicago, IL 60611-2615.

COLUMN D (Historical Cost) - Enter the cost of acquiring the asset and preparing it for use. Do not include goodwill. For buildings, do not include the cost of the land (land is not a depreciable item).

COLUMN E (Prior Period Accumulated Depreciation) - Enter the total amount of straight-line depreciation from prior reporting periods.

COLUMN F (Depreciation for the Reporting Period) - The allowable amount of depreciation for the reporting period is calculated by dividing the Depreciation Basis (Column D) by the years of useful life (Column C) if the asset was in service for the entire reporting period. The allowable amount of depreciation will be less if, during the reporting period, the asset became fully depreciated or the asset was placed into or taken out of service. Fully depreciated means that the total accumulated depreciation (Columns E + F) for the asset is equivalent to the depreciation basis (Column F). For cost-reporting purposes, the provider is to claim a full month of depreciation for the month the asset was placed into service, no matter what day of the month it occurred. Conversely, the provider is not to claim depreciation for the month the asset was taken out of service, no matter what day of the month it occurred. For example, if you purchased a depreciable item in December, you would claim ten months of depreciation on your cost report for that item (December through September). If you sold an item in March, you would claim six months of depreciation for that item (October through March).

SCHEDULE A-2: DEPRECIATION – SPECIALIZED TRANSPORTATION SERVICES

Allowable depreciation expense for specialized transportation services includes only pure straight-line depreciation. No accelerated or additional first-year depreciation is allowable. Any single item purchased during the cost-reporting period costing less than \$5,000 must be expensed and reported accordingly. Depreciation for depreciable items must be calculated using Schedule A and then transferred to the appropriate line item of the cost report.

Required detail must be provided for each depreciable asset (e.g., specialized transportation vehicle or equipment) and each depreciable asset must be assigned a correct estimated useful life.

Minimum useful lives must be consistent with "Estimated Useful Lives of Depreciable Hospital Assets", published by the American Hospital Association (AHA) (Item Number - 061170). Copies of this publication may be obtained by contacting American Hospital Publishing, Inc., Phone: 800-242-2626, Mailing Address: AHPI, Books Division, 737 North Michigan Avenue, Chicago, IL 60611-2615. Please note that this cost report should not include administrative equipment expense.

Follow the instructions for Schedule A-1, with the following changes:

COLUMN C (Years of Useful Life) - enter the estimated useful life of the asset. HHSC requires the following estimated useful lives to be used at a minimum:

Light Trucks & Vans	5 yrs
Buses	7 yrs
Cars and Minivans	3 yrs
Wheelchair lift	5 yrs
Vehicle air conditioning	5 yrs
Harnesses/seat belts/child protective seating	5 yrs

WORKSHEET B: PAYROLL AND BENEFITS

The provider is required to maintain the requested employee information, payroll and benefits, and federal funding reduction information for each individual employee and contracted staff delivering covered services during the reporting period. Report the requested information by type of service provided (e.g., audiology & hearing services).

WORKSHEET C: SPECIALIZED TRANSPORTATION COST FOR IEP STUDENTS

The provider is required to maintain the requested employee information, payroll and benefits, and federal funding reduction information for bus drivers and mechanics. Other transportation costs include: lease/rental, insurance, maintenance and repairs, fuel and oil, major purchases under \$5,000, contracted transportation services and equipment and other transportation costs.

The cost allocation method is the ratio of one way specialized transportation trips provided on a day when medical services pursuant to an IEP were provided divided by the total number of one way specialized transportation trips. One-way trip ratio = (total one-way trips for Medicaid students with IEPs requiring specialized transportation services)/(Total one-way trips for all students with IEPs requiring specialized transportation services).

Appendix A: List of Allowable Direct Medical Services Supplies and Materials

- Adaptive classroom tools (e.g., pencil grips, slant boards, self-opening scissors)
- Audiometer (calibrated annually), tympanometer
- Auditory, speech-reading, speech-language, and communication instructional materials
- Backboard
- Bandages, including adhesive (e.g., Band-Aids) and elastic, of various
- Basins (emesis, wash)
- Battery testers, hearing aid stethoscopes, and earmold cleaning materials
- Blankets, sheets, pillows, and disposable or plastic pillow cases/covers.
- Blood Glucose Meter
- BMI Calculator
- Clinical and instructional materials and supplies;
- Clinical audiometer with sound field capabilities
- Cold packs
- Cotton balls
- Cotton-tip applicators (swabs)
- CPR masks
- Current standardized tests and protocols;
- Dental floss
- Diapers and other incontinence supplies
- Disinfectant
- Disposable gloves (latex-free)
- Disposable gowns
- Disposable Suction Unit
- Ear mold impression materials
- Eating utensils and food
- Electroacoustic hearing aid analyzer
- Electronic Suction Unit
- Evaluation tools (e.g., goniometers, dynamometers, cameras)
- Eye irrigating bottle
- Eye pads
- Eye Wash Bottle
- Eye wash solution
- Fingernail clippers
- First-aid station
- FM amplification systems or other assistive listening devices
- Folding screen or draperies to provide privacy in the clinic
- Glasses Repair Kit
- Glucose Gel
- Gauze
- Ipecac
- Latex gloves
- Loaner or demonstration hearing aids
- Magnifying glass
- Masks
- Materials for nonstandard, informal assessment;
- Materials used to assist students with range of motion, activities of daily living, and instrumental activities of daily living
- Medicine cabinet (with lock)
- Mirrors, brushes, hygiene supplies, and other materials/supplies used to assist with personal hygiene and grooming
- Mobility equipment (e.g., walkers, wheelchairs, scooters)
- Nebulizers
- Otoscope
- Otoscope/ophthalmoscope with battery
- Peak Flow Meters
- Physician's scale that has a height rod and is balanced
- Pill crusher / cutter
- Portable acoustic immittance meter
- Portable audiometer
- Portable crisis kit
- Portable first-aid kit

Appendix A: List of Allowable Direct Medical Service Supplies and Materials (Cont'd)

- Positioning equipment (e.g., wedges, bolsters, standers, adapted seating, exercise mats)
- Record forms (e.g., emergency cards, logs, medical sheets, accident reports, state forms)
- Reflex hammer
- Refrigerator for medicine
- Ring cutter
- Safety pins
- Salt
- Sanitary pads, individually wrapped (may be used for compression)
- Scales
- Scissors (blunt end)
- Scoliometer
- Self-help devices (e.g., spoons, zipper pulls, reachers)
- Sharps container for disposal of hazardous medical waste.
- Slings
- Soap (must be in a dispenser)
- Software and hardware dedicated to the provision of direct medical services for clinical evaluation and instructional software; assistive technology software and hardware
- Sound-level meter
- Sound-treated test booth
- Sphygmomanometer (calibrated annually) and appropriate cuff sizes
- Splints (assorted)
- Stethoscope
- Supplies for adapting materials and equipment (e.g., strapping, Velcro, foam, splinting supplies)
- Surgi-pads
- Syringes (Medication administration / bolus feeding)
- Tape (different widths and hypo-allergenic)
- Tape measure
- Technology devices (e.g., switches, computers, word processors)
- Test materials for central auditory processing assessment
- Test materials for screening speech and language, evaluating speech-reading and evaluating auditory skills
- Thermometer (disposable) or other mechanism for measuring temperature
- Tissues
- Tongue depressors
- Tools (e.g., wrenches, air pumps, electric knives, and electric skillets)
- Triangular bandage
- Tweezers
- Types and materials
- Vinyl gloves (for latex allergies)
- Vision testing machine, such as Titmus
- Visual aids for in-service training
- Visual reinforcement audiometry equipment and other instruments necessary for assessing young or difficult-to-test children
- Wall-mounted height measuring tool
- Washcloths (disposable)
- Wheelchair

STATE OF TEXAS COUNTY CODES

| <u>County Name/Code</u> |
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| Andrews 2 | Crosby 54 | Hemphill 106 | Matagorda 158 | Shelby 210 | |
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| Archer 5 | Dallas 57 | Hill 109 | McLennan 161 | Somervell 213 | |
| Armstrong 6 | Dawson 58 | Hockley 110 | McMullen 162 | Starr 214 | |
| Atascosa 7 | Deaf Smith 59 | Hood 111 | Medina 163 | Stephens 215 | |
| Austin 8 | Delta 60 | Hopkins 112 | Menard 164 | Sterling 216 | |
| Bailey 9 | Denton 61 | Houston 113 | Midland 165 | Stonewall 217 | |
| Bandera 10 | DeWitt 62 | Howard 114 | Milam 166 | Sutton 218 | |
| Bastrop 11 | Dickens 63 | Hudspeth 115 | Mills 167 | Swisher 219 | |
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| Bee 13 | Donley 65 | Hutchinson 117 | Montague 169 | Taylor 221 | |
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| Bosque 18 | Ellis 70 | Jeff Davis 122 | Nacogdoches 174 | Tom Green 226 | |
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| Burnet 27 | Fort Bend 79 | Kenedy 131 | Panola 183 | Victoria 235 | |
| Caldwell 28 | Franklin 80 | Kent 132 | Parker 184 | Walker 236 | |
| Calhoun 29 | Freestone 81 | Kerr 133 | Parmer 185 | Waller 237 | |
| Callahan 30 | Frio 82 | Kimble 134 | Pecos 186 | Ward 238 | |
| Cameron 31 | Gaines 83 | King 135 | Polk 187 | Washington 239 | |
| Carp 32 | Galveston 84 | Kinney 136 | Potter 188 | Webb 240 | |
| Carson 33 | Garza 85 | Kleberg 137 | Presidio 189 | Wharton 241 | |
| Cass 34 | Gillespie 86 | Knox 138 | Rains 190 | Wheeler 242 | |
| Castro 35 | Glasscock 87 | Lamar 139 | Randall 191 | Wichita 243 | |
| Chambers 36 | Goliad 88 | Lamb 140 | Reagan 192 | Wilbarger 244 | |
| Cherokee 37 | Gonzales 89 | Lampasas 141 | Real 193 | Wilacy 245 | |
| Childress 38 | Gray 90 | LaSalle 142 | Red River 194 | Williamson 246 | |
| Clay 39 | Grayson 91 | Lavaca 143 | Reeves 195 | Wilson 247 | |
| Cochran 40 | Gregg 92 | Lee 144 | Refugio 196 | Winkler 248 | |
| Coke 41 | Grimes 93 | Leon 145 | Roberts 197 | Wise 249 | |
| Coleman 42 | Guadalupe 94 | Liberty 146 | Robertson 198 | Wood 250 | |
| Collin 43 | Hale 95 | Limestone 147 | Rockwall 199 | Yoakum 251 | |
| Collinsworth 44 | Hall 96 | Lipscomb 148 | Runnels 200 | Young 252 | |
| Colorado 45 | Hamilton 97 | Live Oak 149 | Rusk 201 | Zapata 253 | |
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| Concho 48 | Hardin 100 | Lubbock 152 | San Jacinto 204 | | |
| Cooke 49 | Harris 101 | Lynn 153 | San Patricio 205 | | |
| Coryell 50 | Harrison 102 | Madison 154 | San Saba 206 | | |
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| Crane 52 | Haskell 104 | Martin 156 | Scurry 208 | | |