



Texas School Health and Related Services (SHARS) Cost Report Instructions

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

SHARS Rate Analyst
512-730-7400
ra_shars@hhsc.state.tx.us

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

Data Development Specialist
512-490-1344
512-833-6043

GENERAL INSTRUCTIONS

Medicaid services provided by school districts in Texas to Medicaid-eligible students are known as School Health and Related Service (SHARS). The oversight of the SHARS program is a collaborative effort between the Texas Education Agency (TEA) and Health and Human Services Commission (HHSC). SHARS allows 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).

Centers for Medicare & Medicaid Services (CMS) requires annual cost reporting, cost reconciliation, and cost settlement processes for all Medicaid SHARS services delivered by school districts. The primary purpose of the cost report is to document the provider's costs for delivering SHARS services to reconcile the provider's interim payments received for SHARS services with its actual total Medicaid allowable costs. To accomplish this task, the HHSC Rate Analysis Department (RAD) utilizes a web-based system for acute care Medicaid cost reporting known as the State of Texas Automated Information Reporting System (STAIRS).

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 HHSC cost-reporting rules and instructions. SHARS providers who are members of a cooperative or shared services arrangement must each submit a separate SHARS Cost Report.

IMPORTANT: CMS requires existing SHARS providers 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, which includes but is not limited to mandatory annual program contact training and certification of all RMTS participants in the district's RMTS Participant List (PL) for the three RMTS quarters conducted in 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 interim Medicaid payments received for SHARS delivered during that annual cost report period. The school district can return and participate in 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 Administrative Claiming by using the link below.

<http://legacy-hhsc.hhsc.state.tx.us/rad/time-study/ts-isd.shtml>

DUE DATE & EXTENSION REQUESTS

The due date for the automated cost report is on or before April 1. Extensions of the 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 review extension requests.

The extension request must clearly explain the necessity for the extension. Not being aware of the due date, inconvenience of due date, the preparer being engaged in other work so the cost report cannot be completed, or the preparer/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 cost report due date. Upon approval, HHSC will specify the new due date.

REPORTING PERIOD

CMS policy states that HHSC require the SHARS Cost Report operate on a federal fiscal year (FFY), which runs October 1 through September 30.

ANNUAL COST REPORT SUBMISSION REQUIREMENT

In accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 355, SubChapter J, Division 23, Rule 8443, each SHARS provider will complete an annual cost report for all SHARS delivered during the previous FFY. 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 RAD. 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 for each line of the cost report back to your trial balance and general ledger accounts.

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 a vendor hold, payment denial code, or disallowance of costs until an acceptable and complete cost report is received by HHSC.

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 \$29.50 should be rounded to \$30. Cost reports submitted without proper rounding of monetary amounts will 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 should 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.

ACCOUNTING METHOD

All information submitted in the cost report 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 the generally accepted accounting principles (GAAP), which are those principles approved by the American Institute of Certified Public Accountants (AICPA).

“PROVIDE DESCRIPTION IN EXPLANATION BOX”

When asked to “provide description in the explanation box”, provide an itemization of the total 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 a non-specific expense category. If necessary, maintain in the documentation file (and properly cross-reference) an additional sheets 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 under 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 percentage 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 UNNACCEPTABLE 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 or disallowance of cost until the requested information has been received by HHSC.

AMENDED COST REPORT

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

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 costs associated with Medicaid. There are four key allocation methods used in the 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 furnishes this number to providers based on a statewide time study.
- The second allocation method is the Direct Medical Services IEP Ratio, which reports the 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. Direct Medical Services IEP Ratio = (The total number of Medicaid students with IEPs requiring medical services) / (The total number of students with IEPs requiring medical services).
- The third allocation method used in the cost report is for transportation costs that cannot be direct costed to specialized transportation services, e.g., fuel, insurance, and/or bus mechanic costs. It is referred to as the Specially-Adapted Vehicles Ratio. If costs cannot be direct costed to specialized transportation services, it is acceptable to allocate the costs to specialized transportation service based on calculating (the number of specialized transportation vehicles) / (the total number of transportation vehicles).
- The fourth allocation method, the One-Way Trip Ratio, 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).

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.

CRRU AUDIT AND HHSC DESK REVIEW

The Cost Report Review Unit (CRRU) will audit the SHARS Cost Reports submitted via the web-based cost reporting system. HHSC RAD will conduct a desk review on each cost report that is not audited by the CRRU team. Audits and desk reviews ensure 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.

Field audits may be performed on select cost reports. If issues arise during a desk review, a field audit may 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 the American Institute of Certified Public Accountants (AICPA) and are issued by the Comptroller General of the United States.

NOTIFICATION OF EXCLUSIONS AND ADJUSTMENTS

HHSC will stay in communication with the district during the audit and/or desk review. HHSC will notify the district via email 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 an audit review, 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. For additional information regarding the submission of an informal review request, please review Title 1 of the Texas Administrative Code, Part 15, Chapter 355, SubChapter A, Rule §355.110.

SHARED SERVICES ARRANGEMENT (SSA) / COOPERATIVE (CO-OP)

Providers who are members of a cooperative or shared services arrangement must each submit a separate SHARS cost report. Each district must have a district-specific Random Moment Time Study (RMTS) participant list (PL) that includes "contracted staff" employed by the fiscal agent and district employees for which costs will be claimed. If you belong to an SSA/Co-op, your costs should only reflect your district specific costs in delivering services. Failure to maintain a complete district-specific PL limits the allowable costs that a district is able to claim on their SHARS cost report.

SSA/Co-op employees are to be recorded in the cost report as employees by the SSA/Co-op fiscal agent. If these individuals provide services at the other member districts of the SSA/Co-op, the member districts should record their portion of the costs as contractor costs. Any worker that only works for a district should be reported as an employee on the district's cost report. Allocation methodologies should appropriately reflect the level of direct service costs associated with the students enrolled in each district.

COMMON COST REPORTING ERRORS

The following is a list of some of the more common errors found on the 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 STAIRS 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 therapist as opposed to 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

1. Expenses reported for activities not related to the services.
2. 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.
3. Expensing capital expenditures (rather than properly depreciating them) for items such as specialized transportation service vehicles.
4. Payroll taxes for Federal Insurance Contributions Act (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.
5. Depreciation costs overstated because of
 - a. Preparer did not use straight-line method and
 - b. 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 prorated 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, it includes temporary substitutes and contract labor. Contracted staff also includes staff members employed by the fiscal agent of a SSA or Co-Op that provide services to SSA or Co-Op member districts.
DEPRECIATION EXPENSE	The periodic reduction of the value of an asset over its useful life or the recovery of the asset 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 worker's compensation costs) and direct care other costs (i.e., 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	Includes counseling services, psychological services (including assessments), physician services, audiology, physical therapy, occupational therapy, speech-language pathology services, nursing services and personal care services.
EMPLOYEE BENEFITS	Includes employer-paid health, life or disability insurance premiums or employer-paid child day care for children of employees paid as employee

	<p>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.</p> <p>Workers' compensation costs refer to expenses associated with employee on the job injuries. Cost 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. 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 liquidating 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.</p>
INDIRECT COST	<p>Indirect cost for school based services is derived by applying the provider specific unrestricted indirect cost rate (UICR). This rate is made available to each provider by TEA. The TEA is the cognizant agency for indirect costs. The provider specific UICR is reported on the cost report, and each district must verify the accuracy of its provider specific UICR.</p>
IEP	<p>Individualized Education Program</p>
NET EXPENSES	<p>Gross expenses less any federal funds, purchase discounts or returns and purchase allowances.</p>
NOT ONLY SPECIALIZED TRANSPORTATION	<p>Reflects transportation employees/contractors whose servicing and/or driving duties float between Specially Adapted Vehicles and regular transportation vehicles.</p>
ONLY SPECIALIZED TRANSPORTATION	<p>Reflects transportation employees/contractors whose primary transportation duties are to service and/or drive a Specially Adapted Vehicle.</p>
PROVIDER	<p>The school district or charter school that has a Medicaid enrollment agreement for providing services under the Texas Medicaid SHARS Program.</p>
PURCHASE DISCOUNTS	<p>Discounts such as reductions in purchase prices resulting from prompt payment or quantity purchases, including trade, quantity and cash</p>

	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 SHARS interim rates for the allowable SHARS services.
SPECIALLY ADAPTED VEHICLE	A vehicle that has been physically modified (i.e., addition of a wheelchair lift, addition of harnesses/protective restraint devices, addition of child protective seating or addition of air conditioning to accommodate students whose IEP includes the documented need for the special adaption).
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 the placement of vendor hold on the providers' 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 (i.e., commercial insurance premiums or the medical bills paid on behalf of an injured employee) are allowable expenses.

SPECIFIC INSTRUCTIONS

IN ORDER TO PROPERLY COMPLETE THE COST RPEORT, 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 and successfully completed a SHARS Cost Report training, provided 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

To access the Reimbursement Methodology Rules, please visit the HHSC Rate Analysis website at <http://www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml> or contact the SHARS Rate Analyst.

GENERAL AND STATISTICAL INFORMATION

SHARS Provider Data - Step 1

District Identification

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), 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.

10- Digit National Provider Identifier (NPI)

Enter your 10-digit NPI number.

If you do not know your correct 10-digit NPI number, please contact the 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.

6-Digit County District Number (CDN)

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.

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.

Financial Contact

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 and successfully completed the HHSC-sponsored

SHARS Cost Report Training. If more than one person prepared the cost report, a Cost Report Certification form must be submitted for each preparer (and each preparer should have attended and successfully completed the SHARS Cost Report training). The preparer must also sign, before a notary, the Cost Report Certification form.

Location of Accounting Records That Support This Report

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 certified public accountant (CPA) or other outside cost report preparer. (See also the RECORDKEEPING section of the General Instructions.)

Cooperative Information

Preparers must answer these two questions in order to help facilitate the agency's review processes. The first asks the preparer to identify who submitted SHARS billings on behalf of the district during the reporting period. If "Contractor/Vendor" is selected the preparer will be required to identify the contractor/vendor. The second asks if the district was a member of a cooperative or shared services arrangement during the reporting period. If the preparer answers "Yes", he or she will be asked to identify the cooperative or shared services arrangement.

SHARS GENERAL AND STATISTICAL INFORMATION - Step 2

General Provider Information

The district's 9-Digit TPI, 10 Digit-NPI and CDN are auto-populated for the district using data entered in Step1. If any of these fields are incorrect, please contact Fairbanks Client Information Center at (888) 321-1225 or info@fairbanksllc.com.

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 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. 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 edit explanation box, explaining why it is less than 12 months.

Unrestricted Indirect Cost Rate (UICR)

Verify the accuracy of the TEA-calculated UICRs for the cost-reporting period reported on the cost report.

Direct Medical Services Percentage Derived from Approved Time Study

This amount will be provided by HHSC.

Federal Medical Assistance Percentage (FMAP)

This amount will be provided by HHSC.

Direct Medical Services Individualized Education Plan (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 (Medicaid and non-Medicaid) that require one or more direct medical service covered under the Medicaid SHARS program during the cost-reporting period.

Intent to Enter Specialized Transportation Expenses

Preparers must answer whether or not the district intends to report Specialized Transportation Expenses. Answering "Yes" enables additional fields. Answering "No" prevents the district from reporting any Specialized Transportation Expenses in the cost report.

Specialized Transportation for IEP Students One-Way Trip Ratio

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 number of one-way trips for Medicaid students with IEPs requiring specialized transportation services

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 number of one-way trips for students with IEPs requiring specialized transportation

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

Allocation of Shared Transportation Costs

This allocation method used in the cost report is for transportation costs that cannot be direct costed to specialized transportation services, e.g., fuel, insurance, and/or bus mechanic costs. It is referred to as the Specially-Adapted Vehicles Ratio.

Total Number of Specially-Adapted Vehicles

Report the total number of vehicles that meet the requirements of a specially-adapted vehicle used by the district to provide transportation services to students.

Total Number of Vehicles

Report the total number of vehicles used by the district to provide transportation services to students.

Contact Information

SHARS Provider Identification, Business Manager/Financial Director and Report Preparer Identification are three areas that are auto-populated by the web-based cost reporting system using data entered in Step 1 of the cost report. Preparers need to verify the accuracy of the information and report any errors to the SHARS Rate Analyst.

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 administrative services
- Counseling Services
- Personal Care Services

The following 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 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 AND HEARING

The definition of audiology and hearing according to the Texas Medicaid State Plan approved by 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

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 approved 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, and outpatient hospital, and 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 laws.

Place of Service:

Audiology and hearing services may be delivered in the following places of service: office, home, outpatient setting, or other location, i.e., 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, i.e., 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, i.e., 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, i.e., 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, i.e., 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, i.e., 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, i.e., 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, i.e., 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, i.e., 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 to all 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 were required to make FICA contributions during the quarters the employees were included on the district's participant list. 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 the qualified provider for the hours he/she provided direct medical services to the district's Medicaid and/or non-Medicaid clients during the quarters the contractor was included on the district's participant list. 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.

IMPORTANT:

Employee Benefits Health Insurance Cost:

SHARS districts are required to report the actual cost incurred by the provider for health insurance costs. School districts with less than 500 employees are required to participate in the statewide health coverage program established in 2002. The plan is administered at the state level as a self-funded plan where the state maintains a trust fund for the funds and pays all claims to providers. The district pays a non-refundable premium to the state for all employees participating in the plan. These insurance premiums should be reported as a cost to the SHARS district in providing health coverage even though it may not be an actual cost to the state. The district is paying a fixed non-recoverable cost to the state for health coverage. District self-funded workers' compensation plans cannot be claimed as a cost in the SHARS Cost Report because the district controls the contribution and the trust fund.

Employee Benefits (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 during the quarters they were reported on the district's participant list. 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, make sure to provide a sufficient description of each type of benefits/insurance and the associated costs for each.

Employee Retirement Contribution (From Worksheet B)

Report the direct-costed employer retirement contributions for the employees during the quarters the employees were included on the district's RMTS PL and whose salaries and wages are reported above.

Employer FICA Payroll Taxes (From Worksheet B)

Report the direct-costed employer-paid Medicare contributions for the employees during the quarters the employees were included in the district's RMTS PL and 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 during the quarters the employees were included in the district's RMTS PL and whose salaries and wages are reported above.

Staff 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 for the quarters the employees were reported on the district's participant list. 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 (TWC Form C-66R (0891) "Notice of Maximum Potential Charge - Reimbursing Employer" or 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 during the quarters the employee was included in the district's RMTS PL and 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 during the quarters the employees were included in the district's RMTS PL and 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 during the quarters the employee was included in the district's RMTS PL and whose salaries and wages are reported above.

DIRECT MEDICAL OTHER

Supplies & Materials

Report direct costed supplies and materials related to all services.

Do not report supplies and materials 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 (i.e., 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 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

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 entry from providers.

SPECIALIZED TRANSPORTATION SERVICES

The definition of specialized transportation services according to the Texas Medicaid State Plan approved by the Centers for Medicare and 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, Diagnostic 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 SHARS on the same day. Transportation services are provided on a specially-adapted vehicle 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, i.e. bus drivers employed by the school district.

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. $\text{One way trip ratio} = \frac{\text{Total one-way trips for Medicaid students with IEPs requiring specialized transportation services}}{\text{Total one-way trips for all students with IEPs requiring specialized transportation services}}$.

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 the district 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 (and 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 (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 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 (TWC Form C66-R (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 including 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 on 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, and 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

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

Other (From Worksheet C)

Report direct costed supplies and materials related to specialized transportation services, such as 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 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 Act (IDEA).

Other

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 entry 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

Much of this page is auto-populated by the web-based cost reporting system, including 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. The form must be completed and signed by the authorized agent and/or representative of the provider, i.e. the Chief Financial Officer, Business Officer, Superintendent or other official legally responsible for the conduct of the provider. Verify all pre-populated data before completing the form.

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 expenses 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. Please note that this cost report should not include administrative expenses.

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 - 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 (i.e. "2013 buses, "2015 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 Places in Service)

Enter the month and year the asset was placed into service. Do not enter "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), FM Application Systems or Other Assistive Listening Devices	10 years
Folding Partitions	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 - 061189). Copies of this publication may be obtained by visiting the AHA Online Store at www.ahaonlinestore.com or by contacting AHA Member and Customer Services Department. Phone: 800-242-2626, E-mail storeservice@aha.org.

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 can be calculated using Schedule A and then transferred to the appropriate line item of the cost report. Please note that this cost report should not include administrative expenses.

Required detail must be provided for each depreciable asset (i.e. 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 Asset", published by the American Hospital Association (AHA) (Item Number - 061189). Copies of this publication may be obtained by visiting the AHA Online Store at www.ahaonlinestore.com or by contacting AHA Member and Customer Services Department. Phone 800-242-2626 or E-mail storeservice@aha.org.

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 years
Buses	7 years
Cars and Minivans	3 years
Wheelchair Lift	5 years
Vehicle air conditioning	5 years
Harnesses/Seat Belts/Child Protective Seating	5 years

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 (i.e., 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 for 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

<ul style="list-style-type: none"> Adaptive classroom tools (e.g., pencil grips, slant boards, self-opening scissors), 	<ul style="list-style-type: none"> Eye pads,
<ul style="list-style-type: none"> Audiometer (calibrated annually), tympanometer, 	<ul style="list-style-type: none"> Eye wash bottle,
<ul style="list-style-type: none"> Auditory, speech-reading, speech-language, and communication instructional materials, 	<ul style="list-style-type: none"> Eye wash solution,
<ul style="list-style-type: none"> Backboard, 	<ul style="list-style-type: none"> Fingernail clippers,
<ul style="list-style-type: none"> Bandages, including adhesive (e.g., Band-Aids) and elastic, of various, 	<ul style="list-style-type: none"> First-aid station,
<ul style="list-style-type: none"> Basins (emesis, wash), 	<ul style="list-style-type: none"> FM amplification systems or other assistive listening devices,
<ul style="list-style-type: none"> Battery testers, hearing aid stethoscopes, and ear mold cleaning materials, 	<ul style="list-style-type: none"> Folding screen or draperies to provide privacy in the clinic,
<ul style="list-style-type: none"> Blankets, sheets, pillows, and disposable or plastic pillow cases/covers, 	<ul style="list-style-type: none"> Glasses repair kit,
<ul style="list-style-type: none"> Blood Glucose Meter, 	<ul style="list-style-type: none"> Glucose gel,
<ul style="list-style-type: none"> BMI Calculator, 	<ul style="list-style-type: none"> Gauze,
<ul style="list-style-type: none"> Clinical and instructional materials and supplies, 	<ul style="list-style-type: none"> Ipecac,
<ul style="list-style-type: none"> Clinical audiometer with sound field capabilities, 	<ul style="list-style-type: none"> Latex gloves,
<ul style="list-style-type: none"> Cold packs, 	<ul style="list-style-type: none"> Loaner or demonstration hearing aids,
<ul style="list-style-type: none"> Cotton balls, 	<ul style="list-style-type: none"> Magnifying glass,
<ul style="list-style-type: none"> Cotton-tip applicators (swabs), 	<ul style="list-style-type: none"> Masks,
<ul style="list-style-type: none"> CPR masks, 	<ul style="list-style-type: none"> Materials for nonstandard, informal assessment,
<ul style="list-style-type: none"> Current standardized tests and protocols, 	<ul style="list-style-type: none"> Materials used to assist students with range of motion, activities of daily living, and instrumental activities of daily living,
<ul style="list-style-type: none"> Dental floss, 	<ul style="list-style-type: none"> Medicine cabinet (with lock)
<ul style="list-style-type: none"> Diapers and other incontinence supplies 	<ul style="list-style-type: none"> Mirrors, brushes, hygiene supplies, and other materials/supplies used to assist with personal hygiene and grooming,
<ul style="list-style-type: none"> Disinfectant, 	<ul style="list-style-type: none"> Mobility equipment (i.e. walkers, wheelchairs, scooters),
<ul style="list-style-type: none"> Disposable gloves (latex-free) 	<ul style="list-style-type: none"> Nebulizers,
<ul style="list-style-type: none"> Disposable gowns, 	<ul style="list-style-type: none"> Otoscope,

• Disposable Suction Unit,	• Otoscope/Ophthalmoscope with battery,
• Ear mold impression materials,	• Peak Flow Meters,
• Eating utensils and food,	• Physician's scale that has a height rod and is balanced,
• Electroacoustic hearing aid analyzer,	• Pill crusher / cutter,
• Electronic Suction Unit,	• Portable acoustic emittance meter,
• Evaluation tools (i.e. goniometers, dynamometers, cameras),	• Portable audiometer,
• Eye irrigating bottle	• Portable crisis kit,
• Positioning equipment (i.e., wedges, bolsters, standers, adapting seating, exercise mats),	• Portable first-aid kit,
• Record forms (i.e., emergency cards, logs, medical sheets, accident reports, state forms),	• Surgi-pads,
• Reflex hammer,	• Syringes (medication administration/bolus feeding),
• Refrigerator for medicine,	• Tape (different widths and hypo-allergenic),
• Ring cutter,	• Tape measure,
• Safety pins,	• Technology devices (i.e., switches, computers, word processors),
• Salt,	• Test materials for central auditory processing assessment,
• Sanitary pads, individually wrapped (may be used for compression),	• Test materials for screening speech and language, evaluating speech-reading and evaluating auditory skills,
• Scales,	• Thermometer (disposable) or other mechanism for measuring temperature,
• Scissors (blunt end),	• Tissues,
• Scoliometer,	• Tongue depressors,
• Self-help devices (i.e. spoons, zipper pulls, reachers),	• Tools (i.e. wrenches, air pumps, electric knives and electric skillets),
• Sharps container for disposal of hazardous medical waste,	• Triangular bandage,
• Slings,	• Tweezers,
• Soap (must be in a dispenser),	• Vinyl gloves (for latex allergies),
• Software and hardware dedicated to the provision of direct medical services for clinical evaluation and instructional software, assistive technology software and hardware,	• Vision testing machine, such as Titmus,
• Sound-level meter,	• Visual aids for in-service training,

<ul style="list-style-type: none"> • Sound-treated test booth, 	<ul style="list-style-type: none"> • Visual reinforcement audiometry equipment and other instruments necessary for assessing young or difficult-to-test children,
<ul style="list-style-type: none"> • Sphygmomanometer (calibrated annually) and appropriate cuff sizes, 	<ul style="list-style-type: none"> • Wall-mounted height measuring tool,
<ul style="list-style-type: none"> • Splints (assorted), 	<ul style="list-style-type: none"> • Washcloths (disposable),
<ul style="list-style-type: none"> • Stethoscope, 	<ul style="list-style-type: none"> • Wheelchair
<ul style="list-style-type: none"> • Supplies for adopting materials and equipment (i.e., strapping, Velcro, foam, splinting supplies), 	

STATE OF TEXAS COUNTY CODES

<u>County Name/Code</u>	<u>County Name/Code</u>	<u>County Name/Code</u>	<u>County Name/Code</u>	<u>County Name/Code</u>	<u>County Name/Code</u>
Anderson 1	Crockett 53	Hays 105	Mason 157	Shackelford 209	
Andrews 2	Crosby 54	Hemphill 106	Matagorda 158	Shelby 210	
Angelina 3	Culberson 55	Henderson 107	Maverick 159	Sherman 211	
Aransas 4	Dalia 56	Hidalgo 108	McCulloch 160	Smith 212	
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	
Baylor 12	Dimmit 64	Hunt 116	Mitchell 168	Tarrant 220	
Bee 13	Donley 65	Hutchinson 117	Montague 169	Taylor 221	
Bell 14	Duval 66	Irion 118	Montgomery 170	Terrell 222	
Bexar 15	Eastland 67	Jack 119	Moore 171	Terry 223	
Blanco 16	Ector 68	Jackson 120	Morris 172	Throckmorton 224	
Borden 17	Edwards 69	Jasper 121	Motley 173	Titus 225	
Bosque 18	Ellis 70	Jeff Davis 122	Nacogdoches 174	Tom Green 226	
Bowie 19	El Paso 71	Jefferson 123	Navarro 175	Travis 227	
Brazoria 20	Erath 72	Jim Hogg 124	Newton 176	Trinity 228	
Brazos 21	Falls 73	Jim Wells 125	Nolan 177	Tyler 229	
Brewster 22	Fannin 74	Johnson 126	Nueces 178	Upshur 230	
Briscoe 23	Fayette 75	Jones 127	Ochiltree 179	Upton 231	
Brooks 24	Fisher 76	Karnes 128	Oldham 180	Uvalde 232	
Brown 25	Floyd 77	Kaufman 129	Orange 181	Val Verde 233	
Burleson 26	Foard 78	Kendall 130	Palo Pinto 182	Van Zandt 234	
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
Comal	46	Hansford	98	Llano	150	Sabine	202	Zavala	254
Comanche	47	Hardeman	99	Loving	151	San Augustine	203		
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		
Cottle	51	Hartley	103	Marion	155	Schleicher	207		
Crane	52	Haskell	104	Martin	156	Scurry	208		