



Health and Human Services Commission

Ambulance Services Supplemental Payment

Cost Report Instructions

Cost Report for the Reporting Period:

10/01/2016 - 09/30/2017

Mailing Address:

Rate Analysis for Acute Care Services
Texas Health and Human Services Commission
4900 North Lamar, Mail Code H-400
Austin, TX 78751

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General

Governmentally owned ambulance providers are eligible to participate in the supplemental payment program if they are directly funded by a local government, hospital authority, hospital district, city, county or state as specified in 42 CFR § 433.50 (i) which describes a unit of government.

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

The Ambulance Services Supplemental Payment Cost Report (cost report) must be prepared and completed a governmental entity on an annual basis for fiscal years ending on September 30. Cost reports are due to HHSC 180 days after the close of the applicable reporting period. A provider who meets the definition of eligible governmental provider and who has been approved to submit a cost report for supplemental payment will prepare the cost report and will attest to, and certify through its cost report the total actual, incurred Medicaid and Uncompensated (uninsured) costs/expenditures, including the federal share and the non-federal share applicable to the cost report period. The completed cost report will be sent to the Texas HHSC at 4900 North Lamar, Mail Code H-400, Austin, TX 78751.

For the cost report to be accurate, only the **SHADED AREAS** of the cost report are to be completed.

Many worksheets (i.e. exhibits) will auto populate with information from another worksheet as to avoid additional extra data entry and to reduce errors. Please review and verify the accuracy of all information on all exhibits before completing the report.

For questions on completing the cost report, please contact the Health and Human Services Commission, Rate Analysis Department at (512) 462-6300.

Definitions:

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

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

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

Direct Cost - means any cost which is identified specifically with a particular final cost objective. Direct costs are not limited to items which are incorporated in the end product as material or labor. Costs identified specifically with a contract are direct costs of that contract. All costs identified specifically with other final cost objectives of the contractor are direct costs of those cost objectives.

Federal Medical Assistance Participation (FMAP) Rate -- is the share of state Medicaid benefit costs paid for by the federal government.

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

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

Medicaid Fee-For-Service (FFS) Paid Claims -- Medicaid payments made by the Health and Human Services Commission through the Texas Medicaid Healthcare Partnership to enrolled providers for services provided to Medicaid recipients.

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

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

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

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

Other third-party coverage -

Commercial (Pay) Health Insurance -- health insurance that covers medical expenses and may also cover disability income. Commercial health insurance can be categorized according to its renewal provisions and type of medical benefits provided. Commercial policies may be sold individually or as part of a group plan.

Self-Pay -- self-pay patient pays in full at the time of visit for our services and we are not required to file claim or submit any documentation on his/her behalf to a third party.

Total Computable Amount – is the total Medicaid allowable amount payable for ambulance services prior to any reductions for interim payments.

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

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

Exhibit A: Cost Report Cover Page

Exhibit A is the cost report cover page. This form includes a provider's National Provider Identification (NPI) number and Texas Provider Identification (TPI) number used by HHSC as a means to obtain fee for service cost data included in the cost report. Each governmental provider must enter their entities legal name, name of person responsible for submitting the cost report, the cost preparers name and physical location, mailing address, phone number and Fax number of all contacts listed. The information will be used by HHSC to contact the provider as necessary through the cost reconciliation and cost settlement process.

DIRECTIONS TO COMPLETE EXHIBIT A

Fiscal Year:

Enter the Federal **Fiscal Year** for which the cost report will be completed (e.g., 2010).
The Federal Fiscal Year begins October 1 and ends September 30 of each year.

Reporting Period:

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

TPI:

Enter the **9-digit TPI** number for the provider that is completing the cost report (e.g. 1234567-89).

NPI:

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

Provider Information

Provider Legal Name:

Enter the **Provider Legal Name** (e.g., (Health and Human Services Commission EMS). This is the name of the provider completing the cost report.

Street Address:

Enter provider **Street Address** (e.g., 4900 N Lamar., Austin, TX 78751. Include the city, state, and zip code in this field.

Mailing Address:

Enter provider **Mailing Address** (e.g., 4900 N Lamar, Austin, TX 78751 or P.O. Box 149030 Mail Code H-400, Austin, TX 78714-9300

Phone Number:

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

Fax Number:

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

Email Address:

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

Business Manager / Financial Director

Business Manager/Financial Directors Name:

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

Title:

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

Agency Name:

Enter the name of the Agency/Municipality/Governmental Entity submitting the cost report.

Mailing Address:

Enter provider **Mailing Address** (e.g., 4900 N Lamar, Austin, TX 787581 or P.O. Box 149030, Mail Code H-400, Austin, TX 78714-9030). Include the city, state, and zip code in this field.

Phone Number:

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

Fax Number:

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

Email Address:

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

Report Preparer Identification

Report Preparer's Name:

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

Title:

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

Mailing Address:

Enter provider **Mailing Address** (e.g., 11209 Metric Blvd., Bldg. H., Austin, TX 78758 or P.O. Box 85700, Mail Code H-400, Austin, TX 78714-9030 Include the city, state, and zip code in this field.

Phone Number:

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

Fax Number:

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

Location of Accounting Records that Support this Report

Records Location:

Enter the **Physical Address** of the location where the provider maintains the accounting records in support of the cost report (e.g., 4900 N. Lamar, Austin, TX 78701). Include the city, state, and zip code in this field.

Exhibit 1: General and Statistical Information

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

DIRECTIONS TO COMPLETE EXHIBIT 1

General Provider Information

Reporting Period – Begin Date:

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

Reporting Period – End Date:

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

Part Year Cost Report:

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

Cost Allocation Information

The purpose of this section is to obtain summary information regarding the cost allocation methodology the governmental entity utilized to allocate costs to various programs, grants, contracts and agreements. Additional information supporting an agencies methodology will be included in Exhibit 7.

Cost Allocation Plan: Enter either Yes or No indicating whether your agency has an approved Cost Allocation Plan (CAP). If the answer is yes, enter the name of the Cognizant Agency that approved the agency CAP.

Please provide a copy of agencies approved IDCR if available; if not available, provide explanation of allocation method used for indirect costs on cost report.

Statistical Information

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

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

Medicaid Fee for Service Paid Claims Amount:

Enter the **Total Ambulance Medicaid fee-for-service (FFS) Paid Claims Amount** for the applicable cost report period identified on the form. The ambulance Medicaid fee-for-service entered must only be for **dates of service** during the cost report period.

Total Billed Charges Associated with Medicaid FFS Paid Claims:

Enter the **Total Billed Charges associated with Medicaid FFS Paid Claims** for the applicable cost report period identified on the form. The total billed charges associated with Medicaid FFS paid claims entered must only be for **dates of service** during the cost report period.

Medicaid Managed Care Organization (MCO) Costs:

Enter the total **MCO** Costs for services provided for the applicable Cost Report period identified on the form. The ambulance Medicaid MCO costs for services entered should be for dates of service during the cost report period.

Total Billed Charges Associated with **MCO** Costs:

Enter the **Total Billed Charges associated with Medicaid MCO Claims** for the applicable cost report period identified on the form. The total billed charges associated with MCO paid claims entered must only be for **dates of service** during the cost report period.

Uninsured/Uncompensated Care – (UC) Uninsured Billed Amounts Associated with UC Costs:

Enter the total **UC** Charity and Bad Debt amounts billed for services provided for the applicable Cost Report period identified on the form. The ambulance UC costs for services entered should be for dates of service during the cost report period and must exclude all unfunded Medicaid and Medicare costs.

Uninsured/Uncompensated Care – (UC) Uninsured Reimbursements Received Associated with **UC** Costs:

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

Total Allowable Costs for Reporting Period:

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

Total Billed Charges for Reporting Period:

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

Additional Cost Data (For Informational Purposes Only)

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

Medicare Costs:

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

Other Third Party Insurance Coverage:

Enter the total **third-party coverage or commercial pay**) Costs for services provided for the applicable cost report period identified on the form. The ambulance “other” costs for services entered should be for dates of service during the cost report period.

Self-Pay, County/City Indigent Recipient Program Costs –

Enter the total **self-pay, or County/City Indigent Recipient Program Costs** for services provided for the applicable cost report period identified on the form. The ambulance “other” costs for services entered should be for dates of service during the cost report period.

Exhibit 2: Direct Medical (Ambulance Services)

Exhibit 2 identifies and summarizes from other exhibits all ambulance services costs within the cost report. Much of the information contained within this exhibit is pulled from either Exhibit 5 or Exhibit 6 which must be completed prior to finalizing Exhibit 2; however, there are unique items of cost that are identified in this exhibit.

Only allocable expenditures related to Medicaid, Medicaid Managed Care and Uncompensated Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program will be included for supplemental payment. This Exhibit sums the personnel expenses and adds additional costs to calculate the total cost of Medical and Uncompensated Care Services.

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

For example, the payroll costs of a direct service employee who works across cost areas within one contracted program would be directly charged to each cost area of that program based upon that employee's continuous daily time sheets and the costs of a direct care employee who works across more than one service delivery area would also be directly charged to each service delivery area based upon that employee's continuous daily time sheets. Health insurance premiums, life insurance premiums, and other employee benefits are applied as direct costs.

Direct Cost Accounting may include:

- a. Dedicated Cost Centers which are comprised of a distinctly identifiable department or unit whose costs are associated with a specific activity; or
- b. Multiple Cost Centers which included cost for those cost centers that are not solely dedicated to one activity but may be allocated to multiple activities.

Governmental providers must use reasonable methods of allocation and must be consistent in their use of allocation methods for cost-reporting purposes across all program areas and business entities. The allocation method should be a reasonable reflection of the actual business operations. Allocation methods that do not reasonably reflect the actual business operations and resources expended toward each unique business entity are not acceptable. Allocated costs are adjusted if HHSC considers the allocation method to be unreasonable. The provider must submit a detailed summary of their cost allocation methodology including a description of the components, the formula for calculating the percentage and any additional supporting documentation as required by HHSC. Supplemental schedules must also be attached to the cost report listing each employee, job title, total salary and benefits, the applicable allocation percentage and the allocation amount that will be included in the cost report. The amounts from the supplemental schedule allocated to the Medicaid and Uncompensated Care programs should match the amounts entered on Exhibit 6 Schedule B with additional detail entered on the following:

Exhibit 7 Schedule C Cost Allocation Methodologies Employed by the Governmental Entity and

Exhibit 8 Schedule D Collections Tracking Form, if applicable. Other forms/reports used to track and calculate UC costs may be used by in place of Exhibit 8, Schedule D.

Any change in cost-reporting allocation methods from one year to the next must be fully disclosed by the contracted provider on its cost report

Indirect Costs Rate

If an Indirect Cost Rate (IDCR) is utilized, that rate must be applied to all appropriate cost objectives specifically identified in the cost report. Indirect cost is calculated by multiplying the Total Allowable costs by the provider's approved indirect cost rate. These indirect rates are developed by the state cognizant agency and are updated annually. The methodology used by the respective cognizant agency to develop the IDCR has been approved by the cognizant federal agency, as required by the CMS guide. Indirect costs are included in the claim as reallocated costs. The provider is responsible to ensure that costs included in the cost report not included in the IDCR, and no costs will be accounted for more than once.

All indirect cost calculations developed to arrive at the total allowable costs must be included in Exhibit 7 - Schedule C of the cost report. All scenarios utilized to calculate the indirect cost must be fully explained as well. The provider must verify that no duplicative costs are included in line 2.33 "Other Cost" (Exhibit 2- Direct Medical). IDCR costs will be disallowed if it is determined that the provider has already claimed those same IDCR costs. All documents that support the indirect cost rate calculation must be maintained by the approved governmental entity and must be made immediately available upon request by HHSC.

Identified reductions, from Exhibit 6, are subtracted to calculate the adjusted amount of Direct Medical Costs allowable as part of the cost report. The cost report identifies the portion of allowable costs that are related to Medicaid FFS, Medicaid MCOs, and Uncompensated Care and applies the cost to charge ratio applicable for the cost report period. The ratio is applied to billed charges associated with Medicaid FFS, Medicaid MCOs, and Uncompensated Care paid claims resulting in the total computable amount for ambulance services. This amount is then reduced by the amount of Medicaid FFS, Medicaid MCOs paid claims and any reimbursement received for Uncompensated Care. The resulting amount is then multiplied by the applicable federal medical assistance percentage (FMAP) to calculate the amount of settlement due to, or owed by (if negative) the provider.

The exhibit is separated into the sections identifying:

Personnel / Payroll Expenses. This section of the Exhibit includes, in part, expenditures from Exhibit 6.

Other Operating Costs. This section of the Exhibit includes, in part, expenditures from Exhibit 5.

Reductions to Allowable Costs. This section of the Exhibit includes reductions to expenditures identified in Exhibit 6.

Cost Settlement Calculation. This section applies the cost to charge ratio calculation methodology to arrive at the final settlement due to or from the provider.

DIRECTIONS TO COMPLETE EXHIBIT 2

Personnel / Payroll Expenses

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

Hours:

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

Regular wage hours
Sick hours
Vacation hours

Payroll Taxes/Unemployment Compensation:

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

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

Other Costs

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

All costs identified in the section of the Exhibit are supported by supplemental schedules to the cost report, and will be supplied at the time of cost report submittal.

Supplies and Materials Costs:

Enter the amount of **Supplies and Materials** expenditures incurred by the provider during the cost report period. Supplies and materials include, but are not limited to, the following:

- Medical supplies
- Office supplies
- Maintenance supplies
- Medical materials

Equipment Costs:

Enter the amount of **Equipment** expenditures incurred by the provider during the cost report period. Equipment expenditures include, but are not limited to, the following non-depreciable items:

- Medical equipment
- Computers
- Radios
- Communications equipment

Support Services Costs:

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

- Information technology salaries, benefits, and operating expenditures
- Telecommunications personnel and operating expenditures

Other Costs:

Enter the amount of **“Other” costs** incurred by the provider during the Cost Report period. Other expenditures may include personnel and non-personnel expenditures depending if the personnel expenditures are represented in the job classification

categories identified in this Exhibit and detailed in Exhibit 6. Other expenditures include, but are not limited to, the following:

- Depreciation expense (Exhibit 5)
- Parent organization allocated costs (discretely identified from prepared cost allocation plan (CAP))
- Other unit personnel and operating expenditures not otherwise identified (Indirect Cost)

Cost Settlement Calculation

Period of Service for Applicable Cost Report Period: Enter the **Period of Service** for the applicable cost report period. Example: 10/01/20XX to 12/31/20XX. For part year cost reports, enter the period of service applicable only to the time frame a cost report is being submitted for.

Total Allowable Costs for Period of Services is the total allowable costs entered into the cost report less any “other federal funding” received (No entry is required).

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

Cost to Charge Ratio (CCR) is the result of dividing a provider’s Total Allowable Costs for the reporting period by the providers Total Billed Charges for the same period.

Total Charges Associated with, Medicaid, Paid Claims, Medicaid Managed Care Claims and Uncompensated Care Paid Fees: Enter the **Total Billed Charges Associated with Medicaid FFS and Medicaid MCO Paid Claims** for the period of service applicable to the cost report.

Total Computable is the total Medicaid Allowable Costs for the period of service applicable to the cost report. The **Total Computable** amount is reduced by the amount of Medicaid Claims paid (Interim Payments) to a provider (TMHP) for the period of service applicable to the cost report. This calculation is equal to the **Settlement Amount** for the reporting period.

Federal Medical Assistance Participation Rate (FMAP): Enter the **FMAP rate** for the appropriate federal fiscal year of the cost report.

Amount due to the Provider is the net amount of the settlement due to or from a provider after the FMAP rate is applied.

Exhibit 3 – Cost Report Certification

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

DIRECTIONS TO COMPLETE EXHIBIT 3

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

Upon completion of all other exhibits in the cost report, please **print this exhibit, sign the exhibit, have the form notarized, scan the exhibit, and include the signed exhibit** when sending the electronic version of the cost report to HHSC. Please have the appropriate person within the provider read and sign the form.

Preparer Identification

Preparer/Contractor Name:

Enter the **Name of** the person that will be/has prepared and entered the cost identified in the cost report (e.g., Jane Doe).

Title:

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

Vendor/Company Name:

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

Signature Authority/Certifying Signature

Certifier Name:

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

Title:

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

Print:

Please print this Exhibit and have the appropriate person identified above sign the certification form. Date:

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

Signature Authority Check Box:

Check the appropriate box that corresponds to the title of the person signing this Exhibit.

Notary:

Upon printing and signing this Exhibit, please have this form **Notarized** by a Notary Public.

Exhibit 4 – Certification of Funds

Exhibit 4 is the Certification of Public Expenditure that allows the state to use the computable Medicaid expenditures as the non-federal match of expenditures to draw the federal portion of Medicaid funding as identified in the settlement. This form attests to, and certifies the accuracy of the provided financial information and that the report was prepared in accordance with State and Federal audit and cost principle standards and that the costs have not been claimed on any other cost report for federal reimbursement purposes. This Exhibit also identifies the amount of local provider expenditure that is allowable for use as the state match

DIRECTIONS TO COMPLETE EXHIBIT 4

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

Upon completion of all other exhibits in the cost report, please **print this exhibit, sign the exhibit, have the form notarized, scan the exhibit, and include the signed exhibit** when sending the electronic version of the cost report to HHSC. Please have the appropriate person within the provider read and sign the form.

Signature Authority/Certifying Signature

Print

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

Date:

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

Certifier Name:

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

Title:

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

Certifier Check Box

Check the appropriate box that corresponds to the title of the person signing this Exhibit. If **Other Agent/Representative** is selected, please include the appropriate title in **Column N, Line 40**.

Notary:

Upon printing and signing this Exhibit, please have this form **Notarized** by a Notary Public.

Exhibit 5 – Schedule A (Depreciation Schedule)

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

DIRECTIONS TO COMPLETE EXHIBIT 5

Vehicles

For depreciation expense related to vehicles, the provider must follow depreciable asset thresholds already in place at the provider and/or parent organization. The vehicle depreciation expense as reported on the Cost Report must come from the provider's depreciation schedule.

Asset Description:

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

Month/Year Placed in Service:

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

Years Useful Life:

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

Cost:

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

Prior Period Accumulated Depreciation:

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

Depreciation for Reporting Period:

Enter the amount of current period depreciation expense in the **Depreciation for Reporting Period** field related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expense incurred during the Cost Report period.

Equipment

For depreciation expense related to equipment, the provider must follow depreciable asset thresholds already in place at the provider and/or parent organization. The equipment depreciation expense as reported on the Cost Report must come from the provider's depreciation schedule.

Asset Description:

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

Month/Year Placed in Service:

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

Years Useful Life:

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

Cost:

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

Prior Period Accumulated Depreciation:

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

Depreciation for Reporting Period:

Enter the amount of current period depreciation expense in the **Depreciation for Reporting Period** field related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expense incurred during the Cost Report period.

Building

For depreciation expense related to buildings where the provider's vehicles or staff is housed with other agencies or entities, **ONLY the portion related to the provider** may be reported. If this is the case, the provider must attach a supplemental exhibit showing how the portion of the building related to the provider was calculated.

Asset Description:

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

Month/Year Placed in Service:

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

Years of Useful Life:

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

Cost:

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

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

Depreciation for Reporting Period:

Enter the amount of current period depreciation expense in the **Depreciation for Reporting Period** field related to the asset as identified on the provider's depreciation schedule. This is the total amount of depreciable expense incurred during the Cost Report period.

Exhibit 6 – Worksheet B (Payroll and Benefits)

This exhibit includes the salary and benefits, and appropriate reductions related to contracted and employed staff of the provider applicable to Medicaid, Medicaid Managed Care and Uncompensated Care. For this Exhibit, all employed and contracted staff related to the provision of Ambulance EMS services should be identified here.

This Exhibit includes several pre-populated staffing classifications for which information will need to be completed. The pre-populated staffing classifications include:

9-1-1 Call Technicians This cost classification includes all personnel salary and benefit expenditures related to operation of emergency communications equipment used in receiving, sending, and relaying medical self-help in response to emergency calls, including, but not limited to:

- 9-1-1 Call Technicians
- 9-1-1 Call Technician Assistants
- ...

Paramedics This cost classification includes all personnel salary and benefit expenditures related to performing basic and advanced medical rescue procedures to access, stabilize, evacuate, and transport a patient to an appropriate medical facility's emergency department, including, but not limited to:

- Paramedics
- EMTs
- ...

Training Coordinators This cost classification includes all personnel salary and benefit expenditures related to providing training, quality, operational, and support of specific ambulance service training and organizational programs, including local pre-paramedic institutions, internal paramedic/communications medic instruction, training activities within Field Operations and Communications, and analysis of performance and quality improvement programs, including, but not limited to:

- Training Coordinators
- ...

Quality Assurance Technicians Quality Assurance Technicians have the same job description as training coordinators above. This cost classification includes all personnel salary and benefit expenditures related to providing training, quality,

operational, and support of specific ambulance service training and organizational programs, including local pre-paramedic institutions, internal paramedic/communications medic instruction, training activities within Field Operations and Communications, and analysis of performance and quality improvement programs, including, but not limited to:

- Quality Assurance Techs
- ...

Safety Officer This cost classification includes all personnel salary and benefit expenditures related to developing, administering, implementing, and evaluating departmental occupational safety program and activities, including, but not limited to:

- Safety Officer
- Safety office assistant
- ...

Billing / Account Reps This cost classification includes all personnel salary and benefit expenditures related to verification of patients' insurance coverage, including Medicaid, collection of third party insurance submissions and payments, and patient customer service related tasks, including, but not limited to:

- Billing representative
- Account representative
- Patient account representative
- ...

CPR Technicians This cost classification includes all personnel salary and benefit expenditures related to the coordination of all EMS activities related to community education of CPR and First Aid skills and techniques, including, but not limited to:

- CPR Techs
- ...

Medical Director) This cost classification includes all personnel salary and benefit expenditures related to the clinical oversight of pre-hospital treatment rendered by EMS personnel. The Medical Director costs shall only include those costs as identified to be related to including, but not limited to:

- Medical Director
- Medical Director Assistant
- ...

Director This cost classification includes all personnel salary and benefit expenditures related to developing, administration, and overall operational effectiveness of the organization including strategic planning, leadership, and oversight of all operational aspects of the EMS Department, including, but not limited to:

- Director
- Director's Assistant
- ...

Public Information Officer This cost classification includes all personnel salary and benefit expenditures related to planning and directing public information, public relations, media relations, or public involvement programs and developing, maintaining, and improving public awareness initiatives, including, but not limited to:

- Public Information Officer
- PIO Assistant
- ...

Contracted EMT/Paramedics This cost classification includes all contracted expenditures related to performing basic and advanced medical rescue procedures to access, stabilize, evacuate, and transport a patient to an appropriate medical facility's emergency department, including, but not limited to:

- Contracted Paramedics
- Contracted EMTs
- ...

DIRECTIONS TO COMPLETE EXHIBIT 6

Employee Information

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

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

Employee #:

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

Last Name:

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

First Name:

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

Job Title/ Credentials:

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

Employee (E) /Contractor (C):

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

Payroll and Benefits

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

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

Gross Salary:

Enter the **Gross Salary** amount for the employee for whom a portion of their salary and/or benefits must be reduced from the total allowable costs.

Contractor Payments:

Enter the amount of **Contractor Payments** for the employee for whom a portion of their salary and/or benefits must be reduced from the total allowable costs.

Employee Benefits:

Enter the amount of **Employee Benefits** for the employee for whom a portion of their salary and/or benefits must be reduced from the total allowable costs. This includes all benefits that are not discretely identified in Columns J-L of this Exhibit.

Employer Retirement:

Enter the amount of **Employer Retirement** expenditure for the employee for whom a portion of their salary and/or benefits must be reduced from the total allowable costs.

FICA:

Enter the amount of **FICA** expenditure for the employee for whom a portion of their salary and/or benefits must be reduced from the total allowable costs.

Payroll Taxes:

Enter the amount of **Payroll Taxes** expenditure for the employee for whom a portion of their salary and/or benefits must be reduced from the total allowable costs.

Federal Funding Reductions

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

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

Allocated Funded Positions Entry:

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

Federal Funding:

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

Other Funds:

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

Salary and Benefits:

Enter the amount of **Salary and Benefits** for all other personnel and staff related to the job classifications identified above, for which no salary or benefit expenditures must be reduced from the total allowable costs.

Exhibit 7-Schedule C – Cost Allocation Methodologies

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

- A. If you entered “yes” on Page 2, Line 1.06, please provide a copy of your agency’s approved Cost Allocation Plan (CAP).
- B. If you entered “yes” on Page 2, Line 1.08, please provide a copy of your agency’s approved Indirect Cost Rate (IDCR).
- C. Please provide a list of personnel cost worksheets that support your CAP or IDCR.
- D. If you entered “no” on Page 2, Line 1.06 and Line 1.08, enter in detail, the allocation methodology that will be used for allocating indirect costs on the cost report.

Exhibit 8-Schedule D –Reasonable Collections Effort Tracking Form EXAMPLE

REASONABLE COLLECTION EFFORT

To be considered a reasonable collection effort, a provider's effort to collect fees for services rendered must include:

Issuance of bills: the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment.

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

Examples of methods and costs used in genuine collection efforts:

Collection Agencies.--A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, it is expected that the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment. When a collection agency obtains payment of an account receivable, the full amount collected must be credited to the patient's account and the collection fee charged to administrative costs. For example, where an agency collects \$40 from the patient/responsible party, and its fee is 50 percent, the agency keeps \$20 as its fee for the collection services and remits \$20 (the balance) to the provider. The provider records the full amount collected from the patient by the agency (\$40) in the patient's account receivable and records the collection fee (\$20) in administrative costs. The fee charged by the collection agency is merely a charge for providing the collection service, and, therefore, is not treated as a bad debt.

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

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

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

Column 1 - Procedure/Transaction ID (Identifier) - Enter the Process /Transaction identifier for service provided to patient.

Column 2 - Procedure Code - Enter the applicable procedure code for the service provided to the patient.

Column 3 - Procedure Description – Enter the description for the procedure code used when transport was provided to the patient.

Column 4 - Transport Date of Service - Enter the date transportation service was provided.

Column 5 - Insurance Carrier Name - Enter the name of the patient’s insurance carrier. If no insurance, enter NA.

Column 6 - Medicaid Recipient Number - Enter the Medicaid/Medicaid Managed Care Recipient Number if the patient is covered by Medicaid or if the patient has a coverage through a managed care organization. Leave this field blank or enter "NA" if the patient is insured by any other means.

Column 7 – Units - Enter the unit of service allowable for ambulance services provided to a client by all modes of approved transportation.

Column 8 - Charge Amounts - Total billed charges for services provided to patient.

Column 9 - Paid Amount(s) - Amounts paid by patient/responsible party for services provided.

Column 10 - If Uninsured, Dates Billed/Notices Sent, Call made - Dates of attempted bill collections or notice sent to patient/responsible party for services provided.

Column 11 - If Uninsured/Uncollectible, Write Off Date - Enter the date receivable was written off.

Column 12 - Total Uncompensated Costs – Enter the amount of uncompensated costs for the reporting periods of service.

Appendix A - List of Participating Providers

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