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

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

SHARS Help Line
512-730-7400
ra_shars@hhsc.state.tx.us

For assistance with tracking of the cost report, contact

512-438-2680
costinformation@hhsc.state.tx.us

Cost Report Preparers List information

512-438-2680
costinformation@hhsc.state.tx.us

Adding Contacts or issues with your State of Texas Automated Information Reporting System (STAIRS) Login

(877) 354-3831
info@fairbanksllc.com

Updated January 27, 2020
Rate Analysis Department – Acute Care Services
TEXAS HEALTH AND HUMAN SERVICES COMMISSION (HHSC)
DISCLAIMER

The information in the Texas School Health and Related Services (SHARS) Cost Report Instructions is for clarification and guidance. This document is not intended to establish policy. For more information, please refer to the Texas Medicaid Provider Procedures Manual, Volume 2, Children’s Services Handbook, Chapter 3, School Health and Related Services (SHARS).

GENERAL INFORMATION

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.

https://rad.hhs.texas.gov/time-study/time-study-independent-school-districts-isd

State of Texas Automated Information System (STAIRS)

STAIRS is the web-based system for long-term care Medicaid cost reporting in the State of Texas.

It is very important that the preparer read these instructions carefully.

Login IDs and passwords do not change year-to-year. The provider’s designated Primary Entity Contact can access STAIRS via the links given in the email notifying them of their login ID and password. If the provider is new for 2019, the provider’s Primary Entity Contact should receive an e-mail with their login information. If the provider’s Primary Entity Contact has not received an e-mail with their login information, they should contact costinformation@hhsc.state.tx.us.

Preparers can only access STAIRS if they are designated as the Preparer by the Primary Entity Contact and have received an e-mail notifying them of their login ID and password for STAIRS.

Cost Report Training

All Texas Health and Human Services Commission (HHSC) sponsored cost report training will be offered via webinar. There will still be separate webinars for new preparers and for those who have taken cost report training in previous years for each program. Each webinar will include both the general and program-specific content for a program.

Upon completion of the appropriate webinar, preparers will be given the appropriate credit to be qualified to submit a cost report. Attendees of a Cost Report Training webinar will not receive a certificate as HHSC Rate Analysis will track training attendance internally. Additionally, there will be NO Continuing Education Units (CEUs) or Continuing Professional Education (CPEs) credits for completing a cost report training webinar.

To be able to submit a 2019 cost report, a preparer must attend the 2019 Cost Report Training Webinar. Preparers without the proper training credit will not be able to access the STAIRS data entry application.
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 sheet(s) 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. reconciled 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 \textit{at least} two decimal places;
7. have complete edit explanations with sufficient detail to explain all variances;
8. be submitted in the STAIRS web-based cost report system; and
9. have signed and notarized, the original certification pages submitted to and received by HHSC on or before posted due dates.

\textbf{RETURN OF UNACCEPTABLE COST REPORTS}
Cost reports that are not in compliance with the above standards will be returned/rejected. The provider will be required to ensure proper completion and resubmission. Failure to resubmit a cost report completed in accordance with all applicable rules and instructions in a timely manner, will result in the placement of a vendor hold or disallowance of cost until the requested information is received by HHSC.

\textbf{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: \texttt{ra_shars@hhsc.state.tx.us}

\textbf{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 are allowable to the extent that it is incurred to support services provided pursuant to an IEP by a Medicaid qualified provider.

\textbf{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.

\textbf{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.

\textbf{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 format compliant 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. 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 appropriate 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 Accounts (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 §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 can 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.
10. Contractor costs; for example, contractor hours per headcount exceeding 50 hours per week, or exceeding the number of weeks in the year school is in session.

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 more than 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.

<table>
<thead>
<tr>
<th>ALLOCATION</th>
<th>Method of distributing costs on a prorate basis. For more information, see COST ALLOCATION METHODS in the General Instructions section.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALLOWABLE COSTS</td>
<td>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.</td>
</tr>
<tr>
<td>CONTRACTED STAFF</td>
<td>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.</td>
</tr>
<tr>
<td>DEPRECIATION EXPENSE</td>
<td>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.</td>
</tr>
<tr>
<td>DIRECT COST</td>
<td>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.</td>
</tr>
<tr>
<td>DIRECT MEDICAL SERVICES</td>
<td>Includes counseling services, psychological services (including assessments), physician services, audiology, physical therapy, occupational therapy, speech-language pathology services, nursing services and personal care services.</td>
</tr>
<tr>
<td>EMPLOYEE BENEFITS</td>
<td>Includes employer-paid health, life or disability insurance premiums or employer-paid child day care for children of employees paid as employee</td>
</tr>
<tr>
<td>EMPLOYEE BENEFITS (Cont.)</td>
<td>benefits on behalf of your staff. Self-insurance paid claims should be properly direct costed and reported as employee benefits. Workers' compensation costs should also be reported as employee benefits. Workers' compensation costs refer to expenses associated with employee on the job injuries. Cost must be reported with amounts accrued for premiums, modifiers and surcharges. Costs must be reported net of any refunds and discounts 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 mean uninsured. Contributions to self-insurance funds that do not represent payments based on current liabilities are unallowable costs.</td>
</tr>
<tr>
<td>INDIRECT COST</td>
<td>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.</td>
</tr>
<tr>
<td>IEP</td>
<td>Individualized Education Program</td>
</tr>
<tr>
<td>NET EXPENSES</td>
<td>Gross expenses less any federal funds, purchase discounts or returns and purchase allowances.</td>
</tr>
<tr>
<td>NOT ONLY SPECIALIZED TRANSPORTATION</td>
<td>Reflects transportation employees/contractors whose servicing and/or driving duties float between Specially Adapted Vehicles and regular transportation vehicles.</td>
</tr>
<tr>
<td>ONLY SPECIALIZED TRANSPORTATION</td>
<td>Reflects transportation employees/contractors whose primary transportation duties are to service and/or drive a Specially Adapted Vehicle.</td>
</tr>
<tr>
<td>PROVIDER</td>
<td>The school district or charter school that has a Medicaid enrollment agreement for providing services under the Texas Medicaid SHARS Program.</td>
</tr>
<tr>
<td>PURCHASE DISCOUNTS</td>
<td>Discounts such as reductions in purchase prices resulting from prompt payment or quantity purchases, including trade, quantity and cash</td>
</tr>
<tr>
<td><strong>PURCHASE DISCOUNTS</strong> (Cont.)</td>
<td>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.</td>
</tr>
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<td>-------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>PURCHASE RETURNS</strong> AND <strong>ALLOWANCES</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>REIMBURSEMENT METHODOLOGY</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>SPECIALY ADAPTED VEHICLE</strong></td>
<td>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).</td>
</tr>
<tr>
<td><strong>VENDOR HOLD</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>WORKERS' COMPENSATION COSTS</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
GENERAL SYSTEM NAVIGATION

Add Record – Used to add lines to the current category. It may be used to add an initial entry to the category or to add Allocation detail to an initial entry. If more lines are needed than initially appear, enter the information for the initially appearing lines, Save, and click Add Record again for more lines.

Edit Record – Check the box beside the record to be edited before clicking this box. This will allow the user to change any specifics previously added to this record.

Delete Record – Check the box beside the record to be deleted before clicking this box. This will delete the selected record.

Save – Used to save the current data. Will save the information in the current location and allow additional Add, Edit or Delete actions.

Save and Return – Saves the current data and returns to the prior level screen.

Cancel – Cancels all unsaved information on the current screen and returns user to the prior level screen.

Stop Signs – A stop sign appears when an action needs to be taken by the preparer in order to either continue or before finalizing the cost report. They will variously tell the preparer that an action must be taken prior to being able to save information in the current screen, that an edit must be responded to before the report can be finalized, or that a required piece of information is needed on the current screen.
SPECIFIC INSTRUCTIONS

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

1. Read these instructions;
2. Read the Reimbursement Methodology Rules for SHARS at Title 1 of the Texas Administrative Code, Part 15, Chapter 355, Subchapter J, Division 23, Rule 8443;
3. Have attended 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 https://rad.hhs.texas.gov/acute-care/school-health-and-related-services-shars or contact the SHARS Help Line.
USER INTERFACE AND DASHBOARD

The initial screen a STAIRS user will see upon logging into the system is the Dashboard. From there the user can see and edit their personal contact information, to include e-mail, address and telephone and fax numbers. This Dashboard page includes important information messages and listings of important dates and upcoming training opportunities. Training registration can be accessed from this page.

By clicking on “Manage” to the right on the top bar, the user can, depending on his or her permissions, add a contact, attach a person to a role or assign a preparer. Refer to the STAIRS – Managing Contacts – Procedures document in the General Reference Material section at the bottom of the STAIRS screen.
The Upload Center is also located under “Manage”. Refer to the Upload File Instructions in the General Reference Materials section on the STAIRS screen.
Once the user is in the system, they can click on “Cost Reporting” on the top bar. If the user has access permission for only a single component code and program, then there will only be one option to click on the initial Cost Reporting page. If the user has access permission for more than one component code and/or program, then the user will need to choose the component code and report in which he or she wishes to work.
GENERAL AND STATISTICAL INFORMATION

SHARS PROVIDER DATA - Step 1

1. Combined Entity Identification

In this section the provider may update telephone, e-mail and address information for the combined entity. If this is a single provider entity with no combined entities, this will be the information for the contracted provider as well.

Entity Contact Identification

In this section, the provider may update the information on the contact person. The contact person must be an employee of the controlling entity, parent company, sole member, governmental body, or related-party management company (i.e., the entire related organization) who is designated on the Entity Contact Certification. The contact person should be able to answer questions about the contents of the provider’s cost report.

Financial Contact

A primary contact may designate a Financial Contact. This person can review the cost report but may not make entries into the system. 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

In accordance with 1 TAC §355.102(d), it is the responsibility of each provider to ensure that each cost report preparer who signs the Cost Report Methodology Certification completes the required HHSC-sponsored cost report training.

The STAIRS cost reporting application will identify whether the person designated as a preparer has completed the required training. Only a preparer who has received credit for one of the cost report trainings (detailed in the next paragraph) from HHSC for both the General and the Program Specific training will be able to complete a cost report in STAIRS. A list of preparers who have completed the

Combined Entity Identification

In this section the provider may update telephone, e-mail and address information for the combined entity. If this is a single provider entity with no combined entities, this will be the information for the contracted provider as well.
training may be accessed through the Rate Analysis website (see the Website section of the Instructions) by scrolling down to the “Training Information” heading and checking on “View Cost Report Training Information”, then “Preparer List.”

Preparers must complete cost report training for every program for which a cost report is submitted. Such training is required every other year for the odd-year cost report for the preparer to be qualified to complete both that odd-year cost report and the following even-year cost report.

Cost report preparers may be employees of the provider or persons who have been contracted by the provider for cost report preparation. NO EXEMPTIONS from the cost report training requirements will be granted.

**Location of Accounting Records that Support this Report**

Enter the address where the provider’s accounting records and supporting documentation used to prepare the 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 the provider’s CPA or other outside cost report preparer. All working papers used in the preparation of the cost report must be maintained in accordance with 1 TAC 355.105(b)(2)(ii). (See also the Recordkeeping section of the General Instructions.)

**SHARS GENERAL AND STATISTICAL INFORMATION - Step 2**

**General Provider Information**

The district's 9-Digit Texas Provider Identifier (TPI), 10 Digit-National Provider Number (NPI) and County District Number (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 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 based on 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 services
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.

Cooperative Information
Preparers must answer these two questions 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.
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

A description of the services and personnel that may deliver the services are found in the Texas Medicaid Provider Procedures Manual, Volume 2, Children’s Services Handbook, Chapter 3, School Health and Related Services (SHARS).
DIRECT MEDICAL SERVICES

In the Cost Report, click “view” to be taken to the Direct Medical Services portion (Section 3).

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.
In Direct Medical Services Payroll, Benefits, and Taxes Costs (Section 3.a), click on “view.” This will take you to the page where the information can be filled out.

Repeat this step through all the sections 3.a through 3.c.
STAFF EXPENSES

Paid Hours (Section 3.a.)
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 (Section 3.a.)
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 (Section 3.a.)
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.

Employee Benefits (Section 3.a.)
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 (Section 3.a.)
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 (Section 3.a.)
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 (Section 3.a.)
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 (Section 3.a.)
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 (Section 3.a.)
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 (Section 3.a.)
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 (Section 3.b.)

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 (Section 3.b.)

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 (Section 3.b.)
This amount transfers from Worksheet B and includes federal funding for any costs reported for all services, except for 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 (Section 3.b.)
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.
In the Cost Report, click “view” to be taken to the Transportation Services Data portion (Section 4).

In Transportation Payroll, Benefits, and Taxes Costs Summary (Section 4.a), click on “view.” This will take you to the page where the information can be filled out.

Repeat this step through all the sections 4.a through 4.d.
Staff Expenses

Paid Hours (Section 4.a.)

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 (Section 4.a.)

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 (Section 4.a.)

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 (Section 4.a.)

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 (Section 4.a.)

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

Employer FICA Payroll Taxes (Section 4.a.)

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

Employer Medicare Payroll Taxes (Section 4.a.)

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

State Unemployment Payroll Taxes (Section 4.a.)

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 (Section 4.a.)

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] (Section 4.a.)

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 (Section 4.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 (Section 4.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 (Section 4.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 (Section 4.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 (Section 4.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 (Section 4.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 (Section 4.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 (Section 4.c.)
Report any payments made to parents for specialized transportation one-way trips.
Other (Section 4.d.)
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
This amount transfers from Section 4.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.
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.

Preparer Verification Summary

After all items for the cost report have been completed, the report is ready for verification. The summary verification screen shows the Direct Medical Services, Transportation Services, the Total SHARS, and the Reimbursable Cost Calculations.
Once the preparer has determined that everything is entered correctly, the report can be verified. The preparer will check the box beside the phrase “I verify that the information entered is correct.” Then click the Verify box at the bottom.

**Preparer Methodology Certification**

This page must be signed by the person identified in Step 1 of this cost report as Preparer. This person must be the individual who actually prepared the cost report or who has primary responsibility for the preparation of the cost report for the provider. Signing as Preparer carries the responsibility for an accurate and complete cost report prepared in accordance with applicable methodology rules and instructions. Signing as Preparer signifies that the preparer is knowledgeable of the applicable methodology rules and instructions and that the preparer has either completed the cost report himself/herself in accordance with those rules and instructions or has adequately supervised and thoroughly instructed his/her employees in the proper completion of the cost report. Ultimate responsibility for the cost report lies with the person signing as Preparer. If more than one person prepared the cost report, an executed Preparer Certification page (with original signature and original notary stamp/seal) may be submitted by each preparer. All persons signing the methodology certification must have attended the required cost report training.
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.
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:

<table>
<thead>
<tr>
<th>Asset</th>
<th>Years of Useful Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiometer</td>
<td>10 years</td>
</tr>
<tr>
<td>Basins (emesis, water)</td>
<td>7 years</td>
</tr>
<tr>
<td>Battery Charger</td>
<td>5 years</td>
</tr>
<tr>
<td>Blood Pressure Device, Electronic</td>
<td>6 years</td>
</tr>
<tr>
<td>Cameras</td>
<td>5 years</td>
</tr>
<tr>
<td>Chart Rack</td>
<td>20 years</td>
</tr>
<tr>
<td>Chart Recorder</td>
<td>10 years</td>
</tr>
<tr>
<td>Defibrillator</td>
<td>5 years</td>
</tr>
<tr>
<td>Item</td>
<td>Useful Life</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Dynamometer, hand</td>
<td>10 years</td>
</tr>
<tr>
<td>Drapery Tracks</td>
<td>10 years</td>
</tr>
<tr>
<td>Electronic Suction Unit (Aspirator), FM Application</td>
<td>10 years</td>
</tr>
<tr>
<td>Systems or Other Assistive Listening Devices</td>
<td>10 years</td>
</tr>
<tr>
<td>Folding Partitions</td>
<td>10 years</td>
</tr>
<tr>
<td>Nebulizer</td>
<td>10 years</td>
</tr>
<tr>
<td>Ophthalmoscope</td>
<td>7 years</td>
</tr>
<tr>
<td>Optical Readers</td>
<td>5 years</td>
</tr>
<tr>
<td>Otoscope</td>
<td>7 years</td>
</tr>
<tr>
<td>Physician's Scale with Height Rod and Balance</td>
<td>10 years</td>
</tr>
<tr>
<td>Refrigerator for Medicine</td>
<td>10 years</td>
</tr>
<tr>
<td>Sanitizer</td>
<td>10 years</td>
</tr>
<tr>
<td>Scoliometer</td>
<td>10 years</td>
</tr>
<tr>
<td>Sphygmomanometer</td>
<td>10 years</td>
</tr>
<tr>
<td>Stethoscope</td>
<td>5 years</td>
</tr>
<tr>
<td>Table, examining</td>
<td>15 years</td>
</tr>
<tr>
<td>Technology Devices (computer, terminals, word processors, printers)</td>
<td>5 years</td>
</tr>
<tr>
<td>Technology Devices (computer software)</td>
<td>3 years</td>
</tr>
<tr>
<td>Thermometer, electric</td>
<td>5 years</td>
</tr>
<tr>
<td>Tympanometer</td>
<td>10 years</td>
</tr>
<tr>
<td>Ultrasonic Cleaner</td>
<td>10 years</td>
</tr>
<tr>
<td>Wheelchair</td>
<td>5 years</td>
</tr>
</tbody>
</table>

**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:

<table>
<thead>
<tr>
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**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

- Audiometer (calibrated annually), tympanometer
- Auditory, speech-reading, speech-language, and communication instructional materials
- Bandages, including adhesive (e.g., Band-Aids) and elastic, of various
- Battery testers, hearing aid stethoscopes, and earmold cleaning materials
- Blood Glucose Meter
- BMI Calculator
- Clinical audiometer with sound field capabilities
- Cold packs
- Cotton balls
- Cotton-tip applicators (swabs)
- Current standardized tests and protocols;
- Dental floss
- Diapers and other incontinence supplies
- Disinfectant
- Disposable gloves (latex-free)
- Disposable gowns
- Disposable Suction Unit
- Ear mold impression materials
- Electroacoustic hearing aid analyzer
- Electronic Suction Unit
- Evaluation tools (e.g., goniometers, dynamometers, cameras)
- Eye pads
- FM amplification systems or other assistive listening devices
- Gauze
- Loaner or demonstration hearing aids
- Materials for nonstandard, informal assessment;
- Materials used to assist students with range of motion,
- Medicine cabinet (with lock)
- Mobility equipment (e.g., walkers, wheelchairs, scooters)
- Nebulizers
- Otoscope
- Otoscope/ophthalmoscope with battery
- Peak Flow Meters
- Physician’s scale that has a height rod and is balanced
- Portable acoustic immittance meter
- Portable audiometer
- Positioning equipment (e.g., wedges, bolsters, standers, adapted seating, exercise mats)
- Reflex hammer
- Sanitary pads, individually wrapped (may be used for compression)
- Scales
- Scoliometer
- Slings
- Sound-level meter
- Sound-treated test booth
- Sphygmomanometer (calibrated annually) and appropriate cuff sizes
- Splints (assorted)
- Stethoscope
- Supplies for adapting materials and equipment (e.g., strapping, Velcro, foam, splinting supplies)
- Surgi-pads
- Syringes (Medication administration / bolus feeding)
- Technology devices (e.g., switches, computers, word processors)
- Test materials for central auditory processing assessment
- Test materials for screening speech and language, evaluating speech-reading and evaluating auditory skills
- Tissues
- Tongue depressors
- Triangular bandage
- Vision testing machine, such as Titmus
- Visual reinforcement audiometry equipment and other instruments necessary for assessing young or difficult-to-test children
- Wheelchair
## STATE OF TEXAS COUNTY CODES

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