

Ambulance Services
Supplemental Payment Program
Cost Report Instructions
Federal Fiscal Year 2023 (DY12)

For assistance with:

ASSPP Program Questions

Provider Finance Hospital Services

Email: pfd_hospitals@hhsc.state.tx.us

Receipt of the report

Phone: (512) 438-2680, Email: costinformationPFD@hhsc.texas.gov

Report Preparers or the list of trained Preparers

Phone: (512) 438-2680, Email: costinformationPFD@hhsc.texas.gov

Adding Contacts or issues with your State of Texas Automated Information Reporting

System (STAIRS) Login:

Fairbanks, LLC. Phone: (877) 354-3831, Email: info@fairbanksllc.com

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General Cost Reporting Information

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 (a)(1)(i) which describes a unit of government. This would include providers such as public health clinics and departments. Providers wanting to participate in the program should contact the Texas Health and Human Services Commission (HHSC), Rate Analysis Department at the UC tools mailbox at pfd_hospitals@hhsc.state.tx.us.

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

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

This cost report is governed by the following rules and instructions:

- 1 TAC §§355.101-105 for the cost determination process and documentation requirements.
- 1 TAC §355.8210 for general rules of the Ambulance UC program and cost calculation.
- 1 TAC §355.8600 for eligibility and reimbursement methodology.
- These written instructions for completion of the report.
- The 2023 cost report training materials.

Also, as stated at 1 TAC §355.105(b)(1), federal tax laws and Internal Revenue Service (IRS) regulations do not necessarily apply in the preparation of Texas Uninsured Charity Care Cost Reports. Except as otherwise specified in HHSC's Cost Determination Process Rules, cost reports should be prepared consistent with generally accepted accounting principles (GAAP). Where the Cost Determination Process Rules and/or program-specific rules conflict with IRS, GAAP or other authorities, the Cost Determination Process Rules and program-specific rules take precedence.

About STAIRS

The completed cost report will be submitted using the State of Texas Automated Information Reporting System (STAIRS) program. STAIRS is the web-based system for Uninsured Charity cost reporting in the State of Texas.

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, the provider's Primary Entity Contact should receive an email with their login information. If the provider's Primary Entity Contact has not received an email with their login information, they should contact costinformationPFD@hpsc.texas.gov. Preparers can only access STAIRS if they have been designated as the Preparer by the Primary Entity Contact and have received an email notifying them of their login ID and password for STAIRS.

Reports will not be considered "received" until the online report has been finalized and all required supporting documents uploaded. Documentation mailed rather than uploaded into the system will not be accepted.

Definitions

Administration Costs - The share of allowable expenses necessary for the general overall operation of the contracted provider's business that is either directly chargeable or properly allocable to this program. Administration costs include office costs and central office costs (i.e., shared administrative costs properly allocated to this program), if applicable. Administration costs are not direct care costs.

Allowable Costs - Expenses that are reasonable and necessary to provide care to Uninsured Charity recipients and are consistent with federal and state laws and regulations. 1 TAC §355.102(a) and §355.103(a)

Bad Debt - Unrecoverable revenues due to uncollectible accounts receivable. Bad debts are not reported on the Uninsured Charity Care cost report. 1 TAC §355.103(b)(17)(M)

Business Component - A separate business entity; a state contract, program, or grant; or an operation separate from the contracted provider's contract that makes up part of the total group of entities related by common ownership or control (i.e., one part of the entire related organization). For an ambulance provider that shares a building with a fire house, the firehouse

and emergency transport would be two separate business components making up one entity.

Charity Care - charges or costs associated with provision of services to individuals under the provider's charity care policies that does not include bad debt, payment shortfall(s), insurance allowances, courtesy allowances, or discounts given to patients who do not meet the provider's charity care policy or financial assistance policy.

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

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

Compensation of Employees - Compensation includes both cash and non-cash forms of compensation subject to federal payroll tax regulations. Compensation includes wages and salaries (including bonuses); payroll taxes and insurance; and benefits. Payroll taxes and insurance include Federal Insurance Contributions Act (old age, survivors, and disability insurance (OASDI) and Medicare hospital insurance); Unemployment Compensation Insurance; and Workers' Compensation Insurance. 1 TAC §355.103(b)(1)

Cost Allocation Plans—are how costs are identified in a logical and systematic manner for reimbursement under federal grants and agreements. The purpose of the Cost Allocation Plan is to ensure costs benefiting multiple fund sources (including Federal, State, and Entity) are distributed fairly among each fund source based on the benefits received.

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

County/City Indigent Programs- programs that help low-income residents who do not qualify for other state or federal health care programs to get access to health care services.

Depreciation Expense - The periodic reduction of the value of an asset over its useful life or the recovery of the asset's cost over the useful life of the asset. For additional information, see Instructions for Step 8.a. 1 TAC §355.103(b)(10)

Direct Cost —means any cost which is identified specifically with a final cost objective. Direct costs are not limited to items which are incorporated in the 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.

Direct Medical Services—health care provided by a licensed or certified provider to a patient.

Federal Medical Assistance Percentage (FMAP) —the share of state Medicaid benefit costs paid for by the federal government.

Indirect Costs—cost incurred and identified with having two or more cost objectives but not specifically identified with any final cost objective. Examples of indirect costs are accounting and legal expenses, administrative salaries, office expenses, rent, security expenses, telephone expenses, and utilities.

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

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

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

Medicaid Managed Care (MCO)—an entity that provides or contracts for managed health care.

Medicaid payments are made by the MCOs to providers for services provided to Medicaid recipients.

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

Modified Total Direct Cost - means all direct salaries and wages, applicable fringe benefits, materials and supplies, services, travel, and subawards and subcontracts up to the first \$25,000 of each subaward or subcontract (regardless of the period of performance of the subawards and subcontracts under the award). MTDC excludes equipment, capital expenditures, charges for patient care, rental costs, tuition remission, scholarships and fellowships, participant support costs and the portion of each subaward and subcontract in excess of \$25,000. Other items may only be excluded when necessary to avoid a serious inequity in the distribution of indirect costs, and with the approval of the cognizant agency for indirect costs in accordance with CFR § 200.68 .

Necessary - Refers to the relationship of the cost, direct or indirect, incurred by a provider to the provision of contracted care. Necessary costs are direct and indirect costs that are appropriate in developing and maintaining the required standard of operation for providing care for individuals in accordance with the contract and state and federal regulations. See TAC reference for additional requirements. 1 TAC 355.102(f)(2)

Reasonable - Refers to the amount expended. The test of reasonableness includes the expectation that the provider seeks to minimize costs and that the amount expended does not exceed what a prudent and cost-conscious buyer pays for a given item or service. See TAC reference for additional considerations in determining reasonableness. 1 TAC 355.102(f)(1)

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

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

Uncompensated Care (UC) —costs of uncompensated care provided to Uninsured Charity Care eligibles for services provided by medical, ambulance or other providers.

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

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

providers treat costs of uninsured patients (less any payments received) as charity costs.

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).

Detailed STAIRS Instructions

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: Click the button 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: Click the button 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 the user to the prior level screen.

Stop Signs: A stop sign appears when an action needs to be taken by the preparer 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 required piece of information is needed on the current screen.

User Interface and Dashboard

The initial screen a STAIRS user will see upon logging into the system is the Dashboard. From here, the user can see and edit their personal contact

information, to include email, address and telephone and fax numbers. Also, on the Dashboard are important information messages and listings of important dates and upcoming training opportunities.

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.

The document titled “Managing Contacts Processing Procedures” gives detailed instructions for managing contacts, including understanding roles and what can be done within the system by persons assigned to the various roles. This document is in the Reference Materials section located at the bottom of all STAIRS pages.

The Upload Center is also located under “Manage”. Once the user is in the system, they can click on “Cost Reporting” on the top bar.

Step 1. Combined Entity Identification

This page is the cost report cover page which reflects all the individuals involved with the Cost Report. Each governmental provider enters its legal name and the appropriate contact information for all parties listed on the form. This information will be used by HHSC to contact the provider during the cost reconciliation and settlement process.

Combined Entity Identification: Enter the Entity’s contact information.

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 governmental agency who is designated to be contacted concerning information reported on the cost report. 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.

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. A list of preparers who have completed the training may be accessed through the Rate Analysis website.

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. To sign as preparer of an even year cost report for new participants, the preparer must attend the appropriate even year Cost Report Training webinar.

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. These records do not refer solely to the work papers used by the provider's 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).

Step 2. General Information

Cost Report Beginning and Ending Dates: This information is pre-populated. Providers that are not in their first year of cost reporting will have a beginning date of 10/01 and ending date of 09/30 respective of the federal fiscal year being reported. Providers that are in their first year of cost reporting will have a beginning date of the first day of the month after their application for enrollment was approved, and the ending date will be 09/30 of the federal fiscal year being reported. If these dates are not correct, contact HHSC Rate Analysis at costinformationPFD@hhs.texas.gov for assistance.

Step 3. Contract Management

The primary purpose of this section is to denote splits in workloads from ambulance centers that may be attached to Fire stations or Hospital.

Step 3.a. Verify Contracts for Requested Reports Active Entire (Cost) Report Period:

Yes or no, to whether the Ambulance center is part of another entity. Select Yes if emergency transport is part of a firehouse or hospital system. Select No if it operates solely as an emergency response agency.

Step 3.b. Enter Other Business Components

The preparer must indicate whether the business was active during the entire cost report period. In most ambulance services, the answer to this question will be "yes." In the next field, indicate what business the ambulance entity is in a relationship with.

Step 3.c. Verify Business Component Summary

This screen lists all cost report business entities contained in Steps 3.a. and 3.b. above. Preparers must answer the question at the bottom of the page to clear the Stop Sign for this step. The question "Are there any other contracts, grants, or business relationships with HHSC, the State of Texas, or with any other business entities not included in the summary table above?" must be answered either "Yes" or "No". An answer of "Yes" will take the preparer back to Step 3.b. above.

Step 4. General Information

Answer the questions on this page. Supporting documentation is required regardless of if preparers have indicated "Yes" for having a Cost Allocation Plan (CAP) and/or an Indirect Cost Rate (IDCR), or wish to use the de minimis rate. If the entity has no approved CAP or IDCR, preparers will need to include supporting documentation that details the allocation methodology being used.

The Direct Medical Utilization percentage is the percentage calculated from either the CAD data or time studies.

Step 5. Statistical Information

Only allocable expenditures related to Uninsured Charity Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program will be included for supplemental payment. Direct cost methods must be used whenever reasonably possible. Direct costing means that allowable costs, direct or indirect, incurred for the benefit of, or directly attributable to, a specific business component must be directly charged to that business component. Direct cost accounting may include:

Dedicated Cost Centers: Cost may be included for those cost centers that are solely dedicated to Uninsured Charity Care.

This page sums the payroll expenses and adds other costs to calculate the allowable cost of ambulance services. Identified reductions, entered manually with support uploaded, are subtracted to calculate the adjusted amount of Ambulance transport costs allowable as part of the cost report. The cost report identifies the portion of allowable charges that are related to Uninsured Charity Care then multiplies these charges by Cost to Charge ratio that is based on total facility charges and costs to calculate the allowable Uninsured Charity Care costs within the cost report period. This cost is then reduced by any reimbursement received for uninsured charity care patients. The resulting shortfall is the total allowable cost for the facilities'

Uncompensated Care (UC) payment and is then multiplied by the applicable federal medical assistance percentage (FMAP) to calculate the federal and state amounts. Please note that this final amount is subject to a further reduction based on available UC dollars when the UC payment is calculated.

Uninsured Charity Care: Enter the total customary/market/commercial charges for individuals that have been classified, meet the requirement and admitted to receive benefit of charity care for the applicable cost report period identified on the form. The ambulance charges for services entered should be for ambulance services approved as charity during the cost report period and must exclude all unfunded Medicaid and Medicare costs and does not include bad debt, payment shortfall(s), insurance allowances, courtesy allowances, or discounts given to patients who do not meet the provider's charity care policy or financial assistance policy.

Uninsured Charity Care Reimbursement: Enter the reimbursements received associated with charity charges for the applicable cost report period identified on the form. The total reimbursements received associated with charity charges entered must only be for dates of service during the cost report period.

Uninsured amount (Non-Charity): Enter the total and upload support for the total entered.

Total Billed Charges Amount Associated with Medicaid FFS Paid Claims: Enter the total and upload support for the total entered.

Total MCO Billed Charges Amount Associated with Medicaid Paid Claims: Enter the total and upload support for the total entered.

Medicare Charges for Reporting Period: Enter the total and upload support for the total entered.

Charges for Other Third-Party Claims for Reporting Period: Enter the total and upload support for the total entered.

Charges for Self-Pay, County/Indigent Recipient Programs for Reporting Period: Enter the total and upload support for the total entered.

All Other Claims within the Reporting Period: Enter the total and upload support for the total entered.

Additional Cost Data: (informational purposes only): In addition to the statistical information entered for cost reporting period, additional cost data is being requested. The total payment data for each charge area.

Charity Care Detail

To support the charity charges a provider needs to provide a copy of the financial assistance or charity care policy used to determine charity care cost and a filled charity care detail template. Both supporting documents are required for payment eligibility. The template has 2 worksheets, the first gives instruction on how to complete the template, the next is the place to document the charges. All claims being included should have write-off dates within the cost reporting year. Dates of service are not required to be within the cost reporting year. Any payments made on the claims should be reported. Bad debt is not allowable to be reported in the charity care template.

Claim Type: Enter the type of claim.

Patient Identifier Number: Enter the unique patient number.

Run Number: enter the unique run number.

Date of Service: Enter the date the service took place.

Procedure Code: Enter the allowable ambulance code for the service that took place.

Charge Description: Enter the description for the procedure code.

Primary Insurance Plan: Enter the patients insurance plan.

Secondary Insurance Plan: Enter the patients secondary insurance plan if applicable.

Total Charges: Enter the total amount the patient was charged.

Charity Charges: Enter the amount of the claims being covered by the provider.

Total Payments: Enter the amount, if any, the provider paid for the service.

Write-off Date: Enter the date of which the charity care application was approved and accepted.

Step 5 B. Data Collection

For use in calculating enhanced supplemental payments for ground emergency ambulance services. Enhanced supplemental payments will be based on the Average Commercial Reimbursement received by providers for services which are covered by Texas Medicaid. Please note that only publicly owned ambulance providers qualify for participation. For additional details please see Texas State Plan Attachment 4.19-B Page 1b.

Please indicate if your facility wishes to participate in the Ground Emergency Ambulance Provider Enhanced Supplemental Payment Program: Choose Yes or No.

If you wish to participate in the Ground Emergency Ambulance Provider Enhanced Supplemental Payment Program fill out the table below, if you enter no you do not need to fill out the table below.

In the table, input the total numbers of units of service and dollar amounts paid by Medicaid and by commercial payers for each CPT code during the year indicated in the third box at the top.

Step 6. Payroll and Benefits

Salary and compensation must be reported on a direct charge basis. This page includes several prepopulated staffing classifications for which information will need to be completed. These pre-populated classifications include:

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 and EMTs and upload support for the total entered. Identified as a direct cost area.

The below roles have been identified as indirect cost areas.

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 and 9-1-1 Call Technician Assistants and upload support for the total entered.

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 and upload support for the total entered.

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 and upload support for the total entered.

Safety Officer: This cost classification includes all personnel salary and benefit expenditures related to developing, administering, implementing, and evaluating departmental occupational safety programs and activities and upload support for the total entered.

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 representatives, account representatives, and patient account representatives and upload support for the total entered.

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 and upload support for the total entered.

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 the EMS department and upload support for the total entered.

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 and upload support for the total entered.

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 and upload support for the total entered.

Input the combined Hours, Wages, Benefits, and Retirement of the staff divided by total, involved in the duties in running the ambulance center. After entering the information, the totals will auto-calculate. When finished entering the information, upload the related support document to the page and upload support for the total entered.

Step 7. Payroll Taxes and Federal Funding Reductions

Enter the totals for the FICA taxes, Medicare Taxes, Federal Funding Reductions, Grants, and any Other Reductions per employee and upload support for the total entered. Do not include the employee's share of the taxes. This amount must equal 7.65% of reported wages. Also indicate whether the ambulance entity has any other reductions not payroll related. If the agency does have other reductions, enter the amount of the remaining reductions, and note the reason in the notes section.

Step 8. Facility and Operations Costs

When first entering the Facility and Operations Costs there are 2 pages of which the provider can enter. If the facility has depreciable assets, enter the information into Step 8.a. If there are no depreciation costs, click to Step 8.b. to enter Facility, Operations, and Other Costs.

For cost-reporting purposes, property and assets owned by the provider and improvements to the provider's owned, leased, or rented property that are valued at \$5,000 or more with an estimated useful life of more than one year at the time of purchase must be depreciated. Any single item costing less than \$5,000 should be expensed and reported as supplies in the applicable cost area.

Allowable depreciation expense includes only pure straight-line depreciation. No accelerated or additional first-year depreciation is allowable. Minimum useful lives must be consistent with "Estimated Useful Lives of Depreciable Hospital Assets", published by the American Hospital Association (AHA) (2013 Version Item Number - Item No. 061189 ISBN: ISBN: 978-1-55648-386-8). Copies of this publication may be obtained by contacting:

Mail: AHA Services, Inc.; P.O. Box 933283; Atlanta, GA 31193-3283

Toll Free: 800-242-2626 Fax: 866-516-5817

Include only assets of the provider that are used directly or indirectly in the provision of direct patient care and/or medical transport during the cost reporting period. For shared depreciation, show the percentage allocated to the provider for which the cost report is being prepared and cross-reference to the applicable allocation summary. For shared facility-level depreciation (e.g., depreciation of assets whose usage is shared between the contracted provider and another entity), show the amount allocated to the provider by cost area and cross-reference the applicable allocation summary.

Required detail must be provided for each depreciable asset and each depreciable asset will be assigned a correct estimated useful life as required by 1 TAC §355.103(b)(7) (A-C).

Depreciation is only available to the assets in Direct Medical provision. Other assets of non-medical entities are not depreciable in consideration of this program. The depreciation schedule identifies allowable depreciation expenses incurred by the provider related to. 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. If the asset or portion thereof has been funded by a separate federal agency, that amount must be reduce from the basis of the asset. If these costs are already claimed or through the cost allocation plan, such costs cannot be claimed again in this section.

Assets that serve more than one cost unit must be allocated by cost unit in accordance with 45 CFR 75.405(d) which states that if a cost benefits two or more projects or activities in proportions that can be determined without undue effort or cost, the cost must be allocated to the projects based on the proportional benefit. If a cost benefits two or more projects or activities in proportions that cannot be determined because of the interrelationship of the work involved, then, notwithstanding 45 CFR 75.405(c), the costs may be allocated or transferred to benefitted projects on any reasonable documented basis. Where the purchase of equipment or other capital asset is specifically authorized under a Federal award, the costs are assignable to the Federal award regardless of the use that may be made of the equipment or other capital asset involved when no longer needed for the purpose for which it was originally required.

Step 8a. Add Record

Depreciable asset information automatically populates from year to year after the initial entry. After the first year, providers will only need to adjust allocations of shared assets to correctly report current year allocation percentages and add new assets. Begin by clicking "Add Record."

1. Is this a shared asset? – Click "Yes" or "No". If "Yes", the preparer will be asked to allocate the asset between business components and cost areas after saving. If "No", the system will automatically assign the asset to the current cost report.

2. Asset – This is the line item on which the allowable cost will appear in the cost report.

3. Code (optional) – For internal provider use. Please use this field to indicate the differences between trucks and ambulances, types of medical equipment, to enter serial numbers of assets, or to name an asset.

4. Description of Asset – This will be chosen from a drop-down menu populated from the AHA Guide discussed in Years of Useful Life below. If the preparer does not find the type of asset and cannot determine a close match, contact HHSC Rate Analysis to determine if a new asset type should be added.

5. Asset in Service at end of Period? – Click "Yes" or "No" to note whether this item was in service at the end of the cost reporting period. If "Yes", enter the Month / Year placed in service. If "No", enter the Month / Year placed in service and the Month / Year removed from service.

6. Years of Useful Life – The period over which the asset must be depreciated. STAIRS populates this with the minimum based on the description chosen.

7. Historical Cost – The cost of acquiring the asset and preparing it for use. Does not include goodwill or, for buildings, the cost of the land (land is not a depreciable item).

8. Salvage Value – This amount will be calculated automatically. Salvage value is the estimated residual value of the asset for scrap or salvage after its useful life has ended.

All buildings must have a minimum salvage value of at least 10% of historical cost for Uninsured Charity Care cost reporting purposes. No other salvage values are required.

9. Depreciation Basis – Calculated figure is the historical cost minus the salvage value.

10. Prior Period Accumulated Depreciation – Calculated figure. Based on the date placed in service and calculation of depreciation on the Depreciation Basis from that date to the beginning date of the cost reporting period.

11. Depreciation for Reporting Period – Calculated figure. Based on the date placed in service, the beginning date of the cost reporting period, any date entered as Month/Year removed from service) and the remaining useful life.

12. Total Expense for Reporting Period – Calculated figure.

13. Click “Save” to enter Business Component and Cost Area Allocation(s) if the asset is shared.

14. Business Component – The available business components are limited to what was entered in Step 3. If a business component that should receive a percentage of the asset is not on the list, then the preparer should return to Step 3.b. and enter the missing business component data. Allocate or direct cost 100% of the asset costs a business component before proceeding. If allocated, an allocation method must be chosen, and an allocation summary uploaded.

Step 8a. Business Component

1. Business Component – The drop-down menu includes all business components for the provider entity. If the provider entity only has one business component, the drop-down menu does not appear, and the single business component is automatically entered under the business component.

2. Click “Add Record” – Generates additional lines to record Cost Area information for each business component. Choose and Click “Add Record” until all business components to which this expense will be allocated have been added.

3. Information in the Business Component Grey Bar –

a) Asset in Service at end of period? – The response for the business component will default to “Yes” if the Asset information above states that the asset itself was in service at the end of the period. This entry field allows for the possibility that the asset is taken out of service for a single business component, but not for all. The allocation of an asset may also change throughout a year. This question allows for flexibility in how asset allocation may change throughout a year.

b) Month/Year Placed in Service (mm/yyyy) – Enter the month and year the asset was initially placed in service for depreciation purposes for this specific business component.

- c) Month/Year Removed from Service (mm/yyyy) – If the asset was removed from service for this business component during the current year, then enter the month and year that the asset was removed from service.
- d) Allocation % – The percentage of the costs to be allocated to this specific business component.
- e) Expense for Reporting Period – Calculated figure based on the percentage(s) entered.

Step 8a. Area Allocation

1. Area – The dropdown menu for “Area” includes all cost areas reportable in this cost report. The only cost area available for selection in the ASSPP program is “Facility, Operations, and Other Costs,” and the allocation to this area will always be 100%.
2. Asset in Service at End of Period? – The response for the cost area will default to “Yes” if the business component information above states that the asset itself was in service at the end of the period. This entry field allows for the possibility that the asset is taken out of service for a single cost area, but not for all.
3. Month/Year Placed in Service – Enter the month and year the asset was initially placed in service for depreciation purposes for this specific cost area.
4. Month/Year Removed from Service – If the asset was removed from service for this cost area during the current year, then enter the month and year that the asset was removed from service.
5. Allocation % – The percentage of the costs to be allocated to this specific cost area.
6. Expense for Reporting Period – Calculated figure based on the percentage(s) entered.
7. Cost Area Allocation Methodology – If allocated to multiple cost areas, an allocation method must be chosen, and an allocation summary must be uploaded. This will be required only if there were multiple cost areas selected.
8. Business Component Allocation Methodology – After all business component cost area allocations have been completed, an expense that is allocated to multiple business components will also require that a business component allocation method be chosen, and an allocation summary uploaded.

Step 8.b. Facility, Operations, and Other Costs

Supplies and Materials: Supplies and materials include but are not limited to medical supplies, office supplies, maintenance supplies, and medical materials. Detail describing the supplies and materials along with the amount and allocation methodology should be uploaded to the Facility, Operations, and Other Costs page. If a cognizant- agency- approved indirect cost rate is used, additional administrative (non-medical) cost will not be permitted. Enter the amounts for direct and indirect and provided support.

Equipment Costs: Equipment costs include but are not limited to the following non-depreciable items: medical equipment, computers, radios, and communication equipment. Detail describing the equipment costs along with the amount and allocation methodology should be uploaded to Facility, Operations, and Other Costs. If a cognizant-agency-approved indirect cost rate is used, additional administrative (nonmedical) cost will not be permitted. Enter the amounts for direct and indirect and provided support.

Support Services: Enter the total and upload the support that reflects that total to Facility, Operations, and Other Costs. Support services expenditures may include personnel and non-personnel expenditures such as information technology salaries, benefits, and operating expenditures and telecommunications personnel and operating expenditures. Enter the amounts for direct and indirect and provided support.

Other Costs: May include personnel and non-personnel expenditures depending on if they are represented in the job classification categories identified in Payroll and Benefits. Other costs may include, but are not limited to, parent organization allocated costs (discretely identified from prepared cost allocation plan (CAP)) and other unit personnel and operating expenditures not otherwise identified (Indirect Cost). Enter the total and upload support related to that total. Enter the amounts for direct and indirect and provided support.

Depreciation: Building & Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, Other Amortization: Enter all buildings, building improvements, building fixed equipment, leasehold improvements, land improvements and amortizable items with a cost of

\$5,000 or more and a useful life of more than one year in Step 8.a. The calculated depreciation will be transferred here.

Step 9. Preparer Summary Verification

Preparer Verification Summary: The amounts on this step are automatically populated using the data entered on the previous steps. 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.

Steps 10. and 11. Preparer Certification and Entity Contact Certification

Certification pages cannot be printed for signing and notarizing until the report has been verified. If the report is reopened for any reason, any previously uploaded certifications will be invalidated and must be completed again.

A preparer may print out both the Preparer and Entity Contact Certification pages at the same time. Once one of the Certification pages is printed, the cost report is completed and locked. If it is discovered that additional changes need to be made, the preparer must contact costinformationPFD@hhs.texas.gov for assistance getting the report(s) reopened.

Certification pages must contain original signatures and original notary stamps/seals when uploaded to STAIRS. These pages must be maintained in original form by the provider. If these pages are not properly completed, the cost report will not be processed until the provider uploads completed pages; if completed pages are not uploaded in a timely manner, the cost report will not be counted as received timely and may be returned. If a report is returned, it is unverified and new certifications, dated after the report has been re-verified will have to be uploaded.

Step 10. Preparer 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 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.

Step 11. Entity Contact Certification

This page must be completed and signed by an individual legally responsible for the conduct of the provider such as an owner, partner, Corporate Officer, Association Officer, Government official. The administrator of one or more of the contracts included in the Cost Report Group may not sign this certification page unless he/she also holds one of those positions. The responsible party's signature must be notarized. The signature date must be the same or after the date the preparer signed the Methodology Certification page, since the cost report certification indicates that the cost report has been reviewed after preparation.

Common Errors Regarding Unallowable Costs

1. Expenses are incorrectly reported for activities that are not related to emergency transport services.
2. Incorrect reporting of personal expenses for items such as personal lunches, personal use of a company vehicle or cellular phone, and personal travel expenses not related to employee business travel.
3. Salaries or expenses incorrectly reported for agency employees who do not perform services for emergency transport.
4. Erroneous reporting as allowable costs those unallowable dues or membership fees to organizations whose primary emphasis is not related to emergency transport.
5. Incorrectly expensing bad debts as "Other" costs.
6. Incorrect reporting of payroll taxes. For example, incorrectly reporting FICA/Medicare taxes at greater than 7.65% of the total reported salaries (excluding central office salaries).

7. Erroneously expensing capital expenditures (rather than properly depreciating them) for items such as roofs, air-conditioning systems, vehicles, sidewalks, and paving of the parking lot.

8. Providing supporting documentation with vague journal entries titled "miscellaneous expense" or "administrative cost."