New Mexico HCBS Rate Study
Cost Report Instructions

The State of New Mexico Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) has contracted with Public Consulting Group, Inc. (PCG) to perform a rate study to identify the time, effort, and costs associated with providing HCBS waiver services to recommend reimbursement rates for the following waiver services:
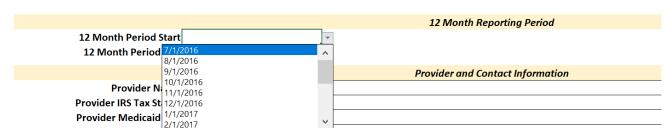
- Developmental Disabilities
- Medically Fragile
- Mi Via (In-home Living Supports and Consultant services only)

PCG will use Developmental Disabilities, Medically Fragile, and Mi Via Waiver-specific expenses from the cost reports and additional level of effort information to propose rate recommendations to DDSD that reflect the true costs associated with the waiver services. This document provides instructions on how to complete the cost report. PCG is available to waiver service providers throughout this engagement via the following toll-free help line and email:

- **Toll Free Help Line: 1-844-225-3658**
- **Email Account:** NMHCBSRateStudy@pcgus.com

The above help line and email account are available to all agency staff for any questions related to the cost report and personnel roster. The help line and email account are both actively monitored during normal business hours (9 a.m. to 5 p.m. Eastern Time). If a PCG employee does not answer the help line, please leave a voicemail and we will return your call as soon as possible. PCG will respond to all calls and emails within one business day. The email account will also serve as the repository for all cost report submissions. ***The completed cost report and accompanying backup documentation must be submitted to PCG by Monday, January 28th, 2019. The cost report should be submitted in its original Microsoft Excel Workbook format. Please do not submit PDFs.***

Please also note that ***this cost report should only contain revenue and expense information incurred by your agency during either the state <u>fiscal year 2017</u> (July 1, 2016 to June 30, 2017) or the <u>calendar year 2017</u> (January 1, 2017 to December 31, 2017).***

New Mexico Developmental Disabilities Supports Division
HCBS Medicaid Waiver Programs Expense Tool for Fiscal Year 2017

		12 Month Reporting Period
12 Month Period Start		
12 Month Period	7/1/2016	
	8/1/2016	
	9/1/2016	*Provider and Contact Information*
	10/1/2016	
Provider N	11/1/2016	
Provider IRS Tax St	12/1/2016	
Provider Medicaid	1/1/2017	
	2/1/2017	

Cost Report Overview

The survey tool is a Microsoft Excel workbook (.xlsx) and is compatible with Microsoft Excel 2003, 2007, 2010, 2013, and 2016. The Cost Report is separated into five (5) sections. Below is a table that summarizes each section:

- *Provider and Contact Information:* Captures your agency's basic contact information
- *Revenue:* Summarizes all revenue supported by the waivers
- *Personnel: Captures* the expense and service information of employees
- *Other Expenses:* Summarizes all other expenses incurred by the waivers
- *Attestation:* Completed by an authorized employee at your agency

Backup Documentation

DDSD needs to validate the information submitted in this cost report using your agency's backup documentation. Please submit all source documentation used to complete the cost report. Examples include audited financial statements that tie directly to the cost report, general ledger extracts, reports from payroll and/or finance departments, and other program-specific reports or comparable documentation.

Provider and Contact Information

This section captures important agency information. It also provides PCG with a main contact person to communicate with throughout the engagement. Below is a listing of definitions for unique fields. Additional fields not listed below such as address should still be completed.

- *Provider Name*: Please enter the agency name you use for all correspondence with DDSD.
- *Provider IRS Tax Status*: Use the dropdown to choose the appropriate tax status.
- *Provider Medicaid ID #*: Please enter the agency's Medicaid ID number.
- *HCBS Program Name (if different)*: Please enter the agency name you use for all correspondence with DDSD if different than the "Provider Name".
- *HCBS Program Address*: Please enter the HCBS program address, including city, state, zip and county name.
- *Contact Name*: The contact person can be employee authorized by the agency to answer questions about the cost report. In addition to contact person name, include contact position, e-mail, and phone number.

Provider and Contact Information	
Provider Name	
Provider IRS Tax Status	
Provider Medicaid ID #	
HCBS Program Name (if different)	
HCBS Program Address	
City, State, Zip	
County	
Contact Name	
Contact Position	
Contact Email	
Contact Phone	

Revenue

This section captures all revenue received by your agency. The "Provider Total $" column captures all revenue received by your agency. The "Developmental Disabilities Waiver $", "Medically Fragile Waiver $", and "Mi Via Waiver $" columns capture the portion of the total revenue that was received

specifically to each waiver. HCBS Program Total $ automatically calculates the total of the above three fields so please do not enter anything here.

Simplified Allocation Method
If major functions benefit from indirect costs to approximately the same degree, indirect costs may be divided by an equitable distribution base.

Multiple Allocation Base Method
If indirect costs benefit an organization's functions to varying degrees, indirect costs must be accumulated into separate cost groups and allocated by a base which best measures the relative benefits to each function (i.e., FTE Supported, Salary supported, etc.)

Revenue						
	Provider Total $	Developmental Disabilities Waiver $	Medically Fragile Waiver $	Mi Via Waiver $	HCBS Program Total $	Notes/Comments
Revenue from HSD: Medicaid					$ -	
Revenue from Other State Agency					$ -	
Other Revenue					$ -	
Total Revenue						

- *Revenue from HSD: Medicaid*: Please enter all Medicaid revenue received from HSD.
- *Revenue from Other State Agency:* Please enter all revenue received from other state agencies other than HSD.
- *Other Revenue:* Please enter other revenue not listed above. In the Notes/Comments box please list the name(s) of the other revenue source(s).
- *Total Revenue:* Please note that this will automatically calculate based on your inputs for the above categories.

Personnel

Personnel						
	Provider Total FTEs	Developmental Disabilities FTEs	Medically Fragile FTEs	Mi Via FTEs	HCBS Program FTEs	Notes/Comments
Employee FTEs					-	
Employee FTEs Vacant					-	

	Provider Hours Per Employee	Developmental Disabilities Waiver Hours Per Employee	Medically Fragile Waiver Hours Per Employee	Mi Via Waiver Hours Per Employee	HCBS Program Total Hours Per Employee	Notes/Comments
Holiday Hours					$ -	
Vacation Hours					$ -	
Sick Hours					$ -	
Training Hours					$ -	
Total Paid Non-Working Hours						

	Provider Total $	Developmental Disabilities Waiver $	Medically Fragile Waiver $	Mi Via Waiver $	HCBS Program Total $	Notes/Comments
Direct Service Salaries					$ -	
Administrative Salaries					$ -	
Personnel Taxes					$ -	
Workers' Compensation					$ -	
Healthcare					$ -	
Retirement					$ -	
Other Fringe Benefits					$ -	
Total Personnel Expenses						

This section captures all expenses related to personnel. In both sections the first column captures all personnel expenses incurred by your agency. The second, third and fourth columns capture the portion of the total personnel expenses that were incurred specifically by each waiver program. HCBS Program Total $ automatically calculates the total of the above three fields so please do not enter anything here.

The first section captures the number of Full Time Employees (FTE) working at your agency that deliver services. Please use a consistent and acceptable allocation method to divide FTEs by waiver if applicable.

The next portion captures holiday hours, vacation hours, sick hours, and training hours. For this section, please calculate the *average hours per employee* at your organization (ex. If your organization has 10 employees, five of which receive 80 vacation hours and five of which receive 100 vacation hours, you would enter 90 vacation hours).

The second section captures salaries (direct service and administrative), personnel taxes, and benefit expenses (Worker's Compensation, healthcare, retirement). For this section calculate the sum of each category across your organization.

- *Holiday Hours*: Please enter the average number of paid holiday hours allocated to personnel.
- *Vacation Hours:* Please enter the average number of paid vacation hours allocated to personnel.
- *Sick Hours:* Please enter the average number of paid sick hours allocated to personnel.
- *Training Hours:* Please enter the average number of paid training hours allocated to personnel.
- *Total Paid Non-Working Hours:* Please note that this will automatically calculate based on your inputs for the above categories.
- *Direct Service Salaries:* Please enter the total salaries paid to personnel associated with the direct service.
- *Administrative Salaries:* Please enter the total salaries paid to personnel not associated with the direct service.
- *Personnel Taxes:* Please enter the total taxes paid for all personnel at your agency.
- *Workers' Compensation:* Please enter the total amount of workers' compensation paid for all personnel.
- *Healthcare:* Please enter the total amount of healthcare benefits paid for all personnel.
- *Retirement:* Please enter the total amount of retirement benefits paid for all personnel.
- *Other Fringe Benefits*: Please enter the total amount of other benefits paid to all personnel that are not included in the above categories.
- *Total Personnel Expenses:* Please note that this will automatically calculate based on your inputs for the above categories.

Other Expenses

	Provider Total $	Developmental Disabilities Waiver $	Medically Fragile Waiver $	Mi Via Waiver $	HCBS Program Total $	Notes/Comments
			Other Expenses			
Mileage					$ -	
Occupancy/Facility					$ -	
Supplies					$ -	
Equipment					$ -	
Liability Insurance					$ -	
Translation/Interpretation/Accommodation Services					$ -	
HCBS Subcontractor					$ -	
Training					$ -	
Transportation					$ -	
Travel					$ -	
Depreciation					$ -	
Gross Receipts Tax					$ -	
Other Operating Expenses					$ -	
Indirect (from Parent Organization)					$ -	
Total Other Expenses					$ -	
Total Expenses						

This section captures all other expenses incurred by your agency. The first column captures the total other expenses incurred by your agency. The second, third and fourth columns capture the portion of the other expenses that were incurred specifically by each waiver program. HCBS Program Total $ automatically calculates the total of the above three fields so please do not enter anything here.

- *Mileage:* Please enter the cost of travel related to mileage reimbursement incurred. This amount should be for mileage reimbursement only, and not vehicle purchases, maintenance or depreciation (which should be lumped into Other Operating Expenses).
- *Occupancy/Facility:* Please enter costs related to the physical facility where your agency operates. This could include rent, property tax, mortgage payments, maintenance, etc.
- *Supplies:* Please enter costs related to supplies including office supplies or other resource materials that your agency incurred.
- *Equipment:* Please enter costs related to equipment that your agency incurred. This could include computers, mobile devices, printers, desks, chairs, etc.
- *Liability Insurance:* Please enter costs related to liability insurance.
- *Translation/Interpretation/Accommodation Services:* Please enter costs related to translation services, interpretation services, or other accommodation requests.
- *HCBS Subcontractor:* Please enter the total cost related to the hiring of subcontractors related to home and community-based services.
- *Training:* Please enter costs related to training. This could include the cost of running internal training and the cost of hiring outside contractors for training purposes.
- *Transportation:* Total amount spent for providing transportation services.
- *Travel:* This amount should be for employee travel reimbursement associated with mileage, trainings, and events attended.
- *Depreciation:* Please enter costs associated with depreciation.
- *Gross Receipts Tax:* Please enter costs related to gross receipts, gross excise, or any other taxes related to revenues.
- *Other Operating Expenses:* Please enter any other costs that were incurred that are not included in the above categories.
- *Indirect (from Parent Organization)*: Please enter any additional indirect costs that are charged to the programs providing waiver services by your parent or umbrella agency.
- *Total Other Expenses:* Please note that this will automatically calculate cased on your inputs for the above categories.
- *Total Expenses:* Please note that this will automatically calculate cased on your inputs for the above categories.

Attestation

This section provides PCG and DDSD with a level of assurance that an individual authorized by your agency has reviewed and approved of the contents of the cost report. Please fill out this section completely.

Authorized Attestation Name:	
Attestation Staff Title:	
Electronic Signature (Retype Name):	
Date of Attestation:	

Returning the Cost Report to PCG

- Ensure that the cost report is filled out completely and signed.
- Please submit the completed cost report and personnel roster in Microsoft Excel format (not in PDF format), as well as all supporting documentation for the cost report via email to NMHCBSRateStudy@pcgus.com on or before January 28th, 2019.