GOVERNMENTAL PROVIDER USE ONLY: CERTIFICATION OF TOTAL COMPUTABLE PUBLIC EXPENDITURE

COMPLETE THIS PAGE ONLY IF THE GOVERNMENTAL PROVIDER IS SUBMITTING A CPE.

1 Governmental Provider Name and Address:

Your NM School District
100 School District Way
Santa Fe, NM 87505

2 Reporting Period:

From: 7/1/2023

To: 6/30/2024

Medicaid Provider Number: 123456789

3 a. Type of Report:

[ ] Partial Period Report

[ ] Amended Cost Report

[X] Full Year Cost Report

3 b. Total Computable Certified Public Expenditures

[X] Medicaid Direct Services

Total Computable Expenditures (From Schedule 9, Line 6): $86,576

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED HEREIN MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.

CERTIFICATION STATEMENT BY OFFICER OF THE PROVIDER

I HEREBY CERTIFY that:

1. I have examined this statement, the accompanying supporting Schedules, the allocation of expenses, services and activities, and the attached worksheets for the period from 7/1/2023 to 6/30/2024 and to the best of my knowledge and belief they are true and correct statements prepared from the books and records of the governmental provider in accordance with applicable instructions.
2. The expenditures included in this statement are based on the actual cost of recorded expenditures and reflect the reporting provider's cost of serving Medicaid recipients during the reporting period under the approved State plan.
3. I am the officer authorized by the referenced governmental provider to submit this form and I have made a good faith effort to assure that all information reported is true and accurate.
4. The required amount of State and/or local funds were used to pay for total computable allowable expenditures included in this statement, and such State and/or local funds were in accordance with all applicable Federal requirements for the non-Federal share match of expenditures (including that the funds were not Federal funds in origin, or are Federal funds authorized by Federal law to be used to match other Federal funds, and that the claimed expenditures were not used to meet matching requirements under other Federally funded programs).
5. The total computable expenditures identified herein are submitted in accordance with 42 CFR 433.51.
6. I understand that this certification of public expenditures serves as the basis for Federal matching funds; that such expenditures were allowable to the State Medicaid program in accordance with all procedures, instructions, and guidance issued by and to the single state agency during the reporting period; and that falsification or concealment of a material fact may be prosecuted under Federal or State civil or criminal law.

SIGNATURE (officer of the governmental provider) _____ DATE _____

TITLE _____ PHONE NUMBER _____

New Mexico Health Care Authority/Medical Assistance Division
CMS School Based Services Cost Report **Schedule 2**

Provider Data **Provider Name:** **Your NM School District**
Provider Number: **123456789**
Reporting Period End: **6/30/2024**

Complete Shaded Areas Only

			Date Month/Day/Year (mm/dd/yyyy)		Date Month/Day/Year (mm/dd/yyyy)
Provider Name	Your NM School District	**Period: FROM**	7/1/2023	**Submission Date**	12/1/2024
Provider Number	123456789	**Period: TO**	6/30/2024		

Contact Information:

County, State	Santa Fe, NM
Business Manager/Finance Director:	John Smith
Prepared by:	John Smith
Phone:	(505) 123-4567
E-mail:	jsmith@santafe.nm.edu
Address 1	100 School District Way
Address 2	
City, State, Zip	Santa Fe, NM 87505

Approved Time Study Information:

Type of Time Study	Random Moment
Period of Time Study	7/1/2023-6/30/2024

Approved Indirect Cost Rate Information:

Cognizant Agency Indirect Cost Rate *	10.00%	To Schedules 4A & 4B & 4C
Name of Cognizant Agency	New Mexico Public Education Department	
Period of Time for which Rate was Approved	7/1/2023-6/30/2024	
Date Indirect Rate was Approved	7/1/2023	

* The indirect cost rate must match the period to which it has been assigned by the cognizant agency.

All providers must use the indirect cost rate assigned by the cognizant agency. For all non institutional providers except school based providers the cognizant agency is generally the Department of Health and Human Services. The Department of Education assigns indirect rates for school based providers.

New Mexico Health Care Authority/Medical Assistance Division
CMS School Based Services Cost Report **Schedule 3**
Cost Allocation Statistics **Provider Name:** **Your NM School District**
Provider Number: **123456789**
Reporting Period End: **6/30/2024**

Only complete the cells below for those statistics applicable to the type of cost being claimed.

Enter Data for Applicable Reporting Period	**Complete Shaded Areas Only**	
Medicaid Eligible Ratio		
Total Medicaid Students		3,000
Total Students in District		6,000
Total Medicaid Students to All Students	To Schedule 4A No-IEP	50.00%
Medicaid IEP/IFSP Eligible Ratio		
Total Medicaid IEP/IFSP Students Receiving Services		1,000
Total IEP/IFSP Students Receiving Services		30,000
Medicaid IEP/IFSP Students to Total IEP/IFSP Students Receiving Services	To Schedules 4A,4B - IEP	3.33%
Transportation for IEP/IFSP Students - Total School District		
Total IEP/IFSP Students Receiving Specialized Transportation		500
Total Students in School District Receiving Transportation		1,000
Total IEP/IFSP Students to Total Students Receiving Transportation	To Schedule 4C	50.00%
School District One Way Trip Ratio		
Medicaid Enrolled IEP/IFSP One-Way Trips		100
Total One-Way Trips on Specialized Vehicle		300
Medicaid IEP/IFSP One-Way Trips to Total IEP/IFSP One-Way Trips	To Schedule 4C	33.33%

New Mexico Health Care Authority/Medical Assistance Division | **Schedule 4A**

CMS School Based Services Cost Report | **Provider Name:** | **Your NM School District**

Summary of Cost by Discipline for IEP/IFSP Medical Services | **Provider Number:** | **123456789**

Reporting Period End: | **6/30/2024**

DO NOT ENTER ANY NUMBERS ON SPREADSHEET. SPREADSHEET AUTOMATICALLY POPULATES WHEN SCHEDULES 2, 3, 5, 6A, 6B, 6C & 6D ARE COMPLETED.

I. Medicaid Providers / Disciplines	Total Salary / Benefits / Other	Apply Direct Medical Time Study Alloc. % from Schedule 5	Apply Indirect Cost Rate Alloc. % from Schedule 2	Subtotal	Medicaid Share: Apply Medicaid IEP/IFSP % from Schedule 3
Allocation % - From Schedules 5, 2, & 3		**45.23%**	**10.00%**		**3.33%**
Audiology Services	$92,650	$41,909	$4,191	$46,100	$1,537
Occupational Therapy	$92,650	$41,909	$4,191	$46,100	$1,537
Physical Therapy	$92,650	$41,909	$4,191	$46,100	$1,537
Behavioral Health Services	$92,650	$41,909	$4,191	$46,100	$1,537
Case Management	$92,650	$41,909	$4,191	$46,100	$1,537
Speech/Language Services	$92,650	$41,909	$4,191	$46,100	$1,537
Nursing Services	$92,650	$41,909	$4,191	$46,100	$1,537
Delegated Nursing Services	$92,650	$41,909	$4,191	$46,100	$1,537
Nutritional Counseling	$92,650	$41,909	$4,191	$46,100	$1,537
Total - All Disciplines	**$833,850**	**$377,184**	**$37,718**	**$414,902**	**$13,830**

As defined and approved in each State Plan or Waiver

To Schedule 9

Medicaid
$13,830

* Support personnel, such as billing staff, may / may not be reported as a direct cost, depending on their treatment by the cognizant agency that assigns the indirect cost rate.

New Mexico Health Care Authority/Medical Assistance Division
CMS School Based Services Cost Report
Summary of Cost by Discipline for 504/BIP/IHP Medical Services

Provider Name: **Your NM School District**
Provider Number: **123456789**
Reporting Period End: **6/30/2024**

Schedule 4A

DO NOT ENTER ANY NUMBERS ON SPREADSHEET. SPREADSHEET AUTOMATICALLY POPULATES WHEN SCHEDULES 2, 3, 5, 6A, 6B, 6C & 6D ARE COMPLETED.

I. Medicaid Providers / Disciplines	Total Salary / Benefits / Other	Apply Direct Medical Time Study Alloc. % from Schedule 5	Apply Indirect Cost Rate Alloc. % from Schedule 2	Subtotal	Medicaid Share: Apply Medicaid % from Schedule 3
Allocation % - From Schedules 5, 2, & 3		**4.38%**	**10.00%**		**50.00%**
Audiology Services	$92,650	$4,056	$406	$4,462	$2,231
Occupational Therapy	$92,650	$4,056	$406	$4,462	$2,231
Physical Therapy	$92,650	$4,056	$406	$4,462	$2,231
Behavioral Health Services	$92,650	$4,056	$406	$4,462	$2,231
Case Management	$92,650	$4,056	$406	$4,462	$2,231
Speech/Language Services	$92,650	$4,056	$406	$4,462	$2,231
Nursing Services	$92,650	$4,056	$406	$4,462	$2,231
Delegated Nursing Services	$92,650	$4,056	$406	$4,462	$2,231
Nutritional Counseling	$92,650	$4,056	$406	$4,462	$2,231
Total - All Disciplines	**$833,850**	**$36,505**	**$3,651**	**$40,156**	**$20,078**

As defined and approved in each State Plan or Waiver

	Medicaid
To Schedule 9	**$20,078**

* Support personnel, such as billing staff, may / may not be reported as a direct cost, depending on their treatment by the cognizant agency that assigns the indirect cost rate.

New Mexico Health Care Authority/Medical Assistance Division | **Schedule 4B**

CMS School Based Services Cost Report | **Provider Name:** | **Your NM School District**

Summary of Other Non-Personnel Medical Cost for IEP/IFSP | **Provider Number:** | **123456789**

Reporting Period End: | **6/30/2024**

DO NOT ENTER ANY NUMBERS ON SPREADSHEET. SPREADSHEET AUTOMATICALLY POPULATES WHEN SCHEDULES 2, 3 & 7 ARE COMPLETED.

I. Direct Medical Supplies, Materials & Other Cost	Direct Other Cost	Apply Indirect Cost Rate Alloc. % from Schedule 2	Subtotal	Medicaid Share: Apply Medicaid IEP/IFSP % from Schedule 3
Allocation % - From Schedules 2 & 3		**10.00%**		**3.33%**
Direct Medical Supplies, Materials & Other Cost	$3,400	$340	$3,740	$125
Direct Medical Supplies, Materials & Other Cost	**$3,400**	**$340**	**$3,740**	**$125**

To Schedule 9

Medicaid
$125

New Mexico Health Care Authority/Medical Assistance Division **Schedule 4C**

CMS School Based Services Cost Report **Provider Name:** **Your NM School District**

Special Education Transportation **Provider Number:** **123456789**

Reporting Period End: **6/30/2024**

DO NOT ENTER ANY NUMBERS ON SPREADSHEET. SPREADSHEET AUTOMATICALLY POPULATES WHEN SCHEDULE 2, 3, 8A & 8B ARE COMPLETED.

I. School District Transportation Costs	Total Salary / Benefits / Other	Apply Indirect Cost Rate Alloc. % from Schedule 2	Subtotal	Apply Ratio of IEP/IFSP Students Receiving Transportation From Schedule 3	Apply School District One Way Trip Ratio From Schedule 3
Allocation % - From Schedule 2 & 3		**10.00%**		**50.00%**	**33.33%**
Bus Drivers	$71,650	$7,165	$78,815	$39,408	$13,136
Mechanics	$71,650	$7,165	$78,815	$39,408	$13,136
Substitute Drivers	$71,650	$7,165	$78,815	$39,408	$13,136
Bus Monitors/Aides	$71,650	$7,165	$78,815	$39,408	$13,136
Fuel	$0	$0	$0	$0	$0
Repairs & Maintenance	$0	$0	$0	$0	$0
Rentals	$0	$0	$0	$0	$0
Contract Use Cost	$0	N/A	$0	$0	$0
Insurance	$ -	$0	$0	$0	$0
Depreciation	$0	$0	$0	N/A	$0
Total - All District Transportation Costs	$286,600	$28,660	$315,260	$157,630	$52,543

To Schedule 9

Medicaid
$52,543

New Mexico Health Care Authority/Medical Assistance Division **Schedule 5**

CMS School Based Services Cost Report **Provider Name:** **Your NM School District**

Time Study Results & Reallocation of General Administrative Time **Provider Number:** **123456789**

Reporting Period End: **6/30/2024**

All Discipline Direct Medical Service Providers **Complete Shaded Areas Only**

Data Entry - Time Study Data	Enter ** Type Activity	Activity % from Time Study	After Reallocation of Gen. Admin.	Direct IEP Medical %	Direct No-IEP Medical %	Category
Code 1.a. - Non Medicaid Outreach	4	0.00226	0.00279	-	-	-
Code 1.b. - Medicaid Outreach	2	0.00076	0.00094	-	-	Admin
Code 2.a. - Facilitating Application for Non-Medicaid Programs	4	0.00025	0.00031	-	-	-
Code 2.b. - Facilitating Medicaid Eligibility Determination	2	-	-	-	-	Admin
Code 3 - School Related and Educational Activities	4	0.08299	0.10240	-	-	-
Code 4.a. - Direct Medical Services - Not Covered as IDEA/IEP Service	4	0.13901	0.17153	-	-	-
Code 4.b. - Direct Medical Services - Covered as IDEA/IEP Service	1	0.36659	0.45234	0.4523		Medical
Code 4.c. - Direct Medical Services - Covered as 504/BIP/IHP Service	1	0.03548	0.04378		0.0438	Medical
Code 5.a. - Transportation for Non-Medicaid Services	4	-	-	-	-	-
Code 5.b. - Transportation - Related Activities of Medicaid Covered Services	2	0.00013	0.00016	-	-	Admin
Code 6.a. - Non-Medicaid Translation	4	0.00012	0.00015	-	-	-
Code 6.b. - Translation related to Medicaid Services	2	0.00013	0.00016	-	-	Admin
Code 7.a. - Planning, Development, and Interagency of Non - Medical Services	4	0.00225	0.00278	-	-	-
Code 7.b. - Planning, Development, and Interagency of Medical Services	2	0.00717	0.00885	-	-	Admin
Code 8.a. - Non-Medical / Non-Medicaid Related Training	4	0.00859	0.01060	-	-	-
Code 8.b. - Medical / Medicaid Training	2	0.02072	0.02557	-	-	Admin
Code 9.a. - Referral, Coordination, and Monitoring of Non - Medicaid Services	4	0.00981	0.01210	-	-	-
Code 9.b. - Referral, Coordination, and Monitoring of Medicaid Services	2	0.13417	0.16555	-	-	Admin
Code 10 - General Administration	3	0.18957				
Code 11 - Non-Paid, Non Work	4	N/A				
Total Allocation Percentage		**1.00000**	**1.00000**	**0.4523**	**0.0438**	

To Schedule 4A

Enter code (1-4) for type of activity **

Enter if activity is for Direct Medical	1
Enter if Medicaid activity is for Direct Administrative	2
Enter if activity is General Administration for reallocation	3
Enter if activity is Non-Medicaid	4

New Mexico Health Care Authority/Medical Assistance Division
CMS School Based Services Cost Report
Direct Cost by Discipline

Provider Name: **Your NM School District**
Provider Number: **123456789**
Reporting Period End: **6/30/2024**

Schedule 6A

Complete Shaded Areas Only

Employee Information						Funding and Percentages (Adjustments)				
Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Total Gross Salary	Is position fully funded by other Federal funds? Yes or No	If yes, automatically remove 100%	Is position partially funded by Federal Funds? Yes or No	Enter Amount of Federal Funded Salary	Other amounts to be removed
Audiology Services										
Trial Balance					$ 100,000					
Reductions to Trial balance										
1234	Smith	Jack		Employee	$ 25,000	yes	$ 25,000	No		
4321	Smith	Jane		Vendor	$ 25,000	no	$ -	Yes	$ 10,000	
3214	Smith	John		Employee	$ 25,000	no	$ -	Yes	$ 5,000	$ 2,500
							$ -			
							$ -			
							$ -			

Audiology Services

Occupational Therapy										
Trial Balance					$ 100,000					
Reductions to Trial Balance										
1234	Howard	Henry		Employee	$ 25,000	yes	$ 25,000	No		
4321	Howard	Harry		Vendor	$ 25,000	no	$ -	Yes	$ 10,000	
3214	Howard	Henrietta		Employee	$ 25,000	no	$ -	Yes	$ 5,000	$ 2,500
							$ -			
							$ -			
							$ -			

Occupational Therapy

Physical Therapy										
Trial Balance					$ 100,000					
Reductions to Trial Balance										
1234	James	Steve		Employee	$ 25,000	yes	$ 25,000	No		
4321	James	John		Vendor	$ 25,000	no	$ -	Yes	$ 10,000	
3214	James	Mike		Employee	$ 25,000	no	$ -	Yes	$ 5,000	$ 2,500

Physical Therapy

Behavioral Health Services										
Trial Balance					$ 100,000					
Reductions to Trial Balance										
1234	Donovan	Harry		Employee	$ 25,000	yes	$ 25,000	No		
4321	Donovan	Mike		Vendor	$ 25,000	no	$ -	Yes	$ 10,000	
3214	Donovan	Sally		Employee	$ 25,000	no	$ -	Yes	$ 5,000	$ 2,500

Behavioral Health Services

Case Management										
Trial Balance					$ 100,000					
Reductions to Trial Balance										
1234	Kerry	Belinda		Employee	$ 25,000	yes	$ 25,000	No		
4321	Kerry	Tawny		Vendor	$ 25,000	no	$ -	Yes	$ 10,000	
3214	Kerry	Mike		Employee	$ 25,000	no	$ -	Yes	$ 5,000	$ 2,500

Case Management

New Mexico Health Care Authority/Medical Assistance Division
CMS School Based Services Cost Report
Direct Cost by Discipline

Provider Name: **Your NM School District**
Provider Number: **123456789**
Reporting Period End: **6/30/2024**

Schedule 6B

Complete Shaded Areas Only

Employee Information						Payroll and Benefits					
Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Total Gross Salary	Reductions to Gross Salary	Employee Benefits	Employer- FICA (if not covered under employee benefits)	Medicare Tax - Employer - (if not listed under employee benefits)	Vendor / Contractor Payments	Adjusted Salary & Benefits & Vendor Payments
Audiology Services											
Trial Balance					$ 100,000	$ 100,000	$ 10,000	$ 1,000	$ 500	$ 25,000	**$ 136,500**
Reductions to Trial balance											
1234	Smith	Jack		Employee	$ 25,000	$ 25,000					**$ 25,000**
4321	Smith	Jane		Vendor	$ 25,000	$ 10,000					**$ 10,000**
3214	Smith	John		Employee	$ 25,000	$ 7,500	$ 1,000	$ 250	$ 100		**$ 8,850**
						$ -					**$ -**
						$ -					**$ -**
						$ -					**$ -**
	Audiology Services					$ 57,500	$ 9,000	$ 750	$ 400	$ 25,000	**$ 92,650** To Sch.4A
Occupational Therapy											
Trial Balance					$ 100,000	$ 100,000	$ 10,000	$ 1,000	$ 500	$ 25,000	**$ 136,500**
Reductions to Trial Balance											
1234	Howard	Henry		Employee	$ 25,000	$ 25,000					**$ 25,000**
4321	Howard	Harry		Vendor	$ 25,000	$ 10,000					**$ 10,000**
3214	Howard	Henrietta		Employee	$ 25,000	$ 7,500	$ 1,000	$ 250	$ 100		**$ 8,850**
						$ -					**$ -**
						$ -					**$ -**
						$ -					**$ -**
	Occupational Therapy					$ 57,500	$ 9,000	$ 750	$ 400	$ 25,000	**$ 92,650** To Sch.4A
Physical Therapy											
Trial Balance					$ 100,000	$ 100,000	$ 10,000	$ 1,000	$ 500	$ 25,000	**$ 136,500**
Reductions to Trial Balance											
1234	James	Steve		Employee	$ 25,000	$ 25,000					**$ 25,000**
4321	James	John		Vendor	$ 25,000	$ 10,000					**$ 10,000**
3214	James	Mike		Employee	$ 25,000	$ 7,500	$ 1,000	$ 250	$ 100		**$ 8,850**
						$ -					**$ -**
						$ -					**$ -**
						$ -					**$ -**
	Physical Therapy					$ 57,500	$ 9,000	$ 750	$ 400	$ 25,000	**$ 92,650** To Sch.4A
Behavioral Health Services											
Trial Balance					$ 100,000	$ 100,000	$ 10,000	$ 1,000	$ 500	$ 25,000	**$ 136,500**
Reductions to Trial Balance											
1234	Donovan	Harry		Employee	$ 25,000	$ 25,000					**$ 25,000**
4321	Donovan	Mike		Vendor	$ 25,000	$ 10,000					**$ 10,000**
3214	Donovan	Sally		Employee	$ 25,000	$ 7,500	$ 1,000	$ 250	$ 100		**$ 8,850**
						$ -					**$ -**
						$ -					**$ -**
						$ -					**$ -**
	Behavioral Health Services					$ 57,500	$ 9,000	$ 750	$ 400	$ 25,000	**$ 92,650** To Sch.4A
Case Management											
Trial Balance					$ 100,000	$ 100,000	$ 10,000	$ 1,000	$ 500	$ 25,000	**$ 136,500**
Reductions to Trial Balance											
1234	Kerry	Belinda		Employee	$ 25,000	$ 25,000					**$ 25,000**
4321	Kerry	Tawny		Vendor	$ 25,000	$ 10,000					**$ 10,000**
3214	Kerry	Mike		Employee	$ 25,000	$ 7,500	$ 1,000	$ 250	$ 100		**$ 8,850**
						$ -					**$ -**
						$ -					**$ -**
						$ -					**$ -**
	Case Management					$ 57,500	$ 9,000	$ 750	$ 400	$ 25,000	**$ 92,650** To Sch.4A

New Mexico Health Care Authority/Medical Assistance Division
CMS School Based Services Cost Report
Direct Cost by Discipline - Continuation

Schedule 6C
Provider Name: **Your NM School District**
Provider Number: **123456789**
Reporting Period End: **6/30/2024**

Complete Shaded Areas Only

Employee Information						Funding and Percentages (Adjustments)				
Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Total Gross Salary	Is position fully funded by other Federal funds? Yes or No	If yes, automatically remove 100%	Is position partially funded by Federal Funds? Yes or No	Enter Amount of Federal Funded Salary	Other amounts to be removed
Speech/Language Services										
Trial Balance					$ 100,000					
Reductions to Trial Balance										
1234	Doe	Jane		Employee	$ 25,000	yes	$ 25,000	No		
4321	Doe	John		Vendor	$ 25,000	no	$ -	Yes	$ 10,000	
3214	Doe	Jessica		Employee	$ 25,000	no	$ -	Yes	$ 5,000	$ 2,500

Speech/Language Services

Nursing Services										
Trial Balance					$ 100,000					
Reductions to Trial Balance										
1234	Sanchez	Sasha		Employee	$ 25,000	yes	$ 25,000	No		
4321	Sanchez	Steve		Vendor	$ 25,000	no	$ -	Yes	$ 10,000	
3214	Sanchez	Jose		Employee	$ 25,000	no	$ -	Yes	$ 5,000	$ 2,500

Nursing Services

Delegated Nursing Services										
Trial Balance					$ 100,000					
Reductions to Trial Balance										
1234	Rodriguez	Robin		Employee	$ 25,000	yes	$ 25,000	No		
4321	Rodriguez	Rob		Vendor	$ 25,000	no	$ -	Yes	$ 10,000	
3214	Rodriguez	Roberto		Employee	$ 25,000	no	$ -	Yes	$ 5,000	$ 2,500

Delegated Nursing Services

Nutritional Counseling										
Trial Balance					$ 100,000					
Reductions to Trial Balance										
1234	Smithfield	Wells		Employee	$ 25,000	yes	$ 25,000	No		
4321	Smithfield	Watson		Vendor	$ 25,000	no	$ -	Yes	$ 10,000	
3214	Smithfield	Joaquin		Employee	$ 25,000	no	$ -	Yes	$ 5,000	$ 2,500

Nutritional Counseling

New Mexico Health Care Authority/Medical Assistance Division
CMS School Based Services Cost Report
Direct Cost by Discipline - Continuation

Schedule 6D
Provider Name: **Your NM School District**
Provider Number: **123456789**
Reporting Period End: **6/30/2024**

Complete Shaded Areas Only

Employee Information						Payroll and Benefits						
Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Total Gross Salary	Reductions to Gross Salary	Employee Benefits	Employer- FICA (if not covered under employee benefits)	Medicare Tax - Employer - (if not listed under employee benefits)	Vendor / Contractor Payments	Adjusted Salary & Benefits & Vendor Payments	
Speech/Language Services												
Trial Balance					$ 100,000	$ 100,000	$ 10,000	$ 1,000	$ 500	$ 25,000	**$ 136,500**	
Reductions to Trial Balance												
1234	Doe	Jane		Employee	$ 25,000	$ 25,000					**$ 25,000**	
4321	Doe	John		Vendor	$ 25,000	$ 10,000					**$ 10,000**	
3214	Doe	Jessica		Employee	$ 25,000	$ 7,500	$ 1,000	$ 250	$ 100		**$ 8,850**	
						$ -					**$ -**	
						$ -					**$ -**	
						$ -					**$ -**	
Speech/Language Services						$ 57,500	$ 9,000	$ 750	$ 400	$ 25,000	**$ 92,650**	To Sch 4A
Nursing Services												
Trial Balance					$ 100,000	$ 100,000	$ 10,000	$ 1,000	$ 500	25,000	$ 136,500	
Reductions to Trial Balance												
1234	Sanchez	Sasha		Employee	$ 25,000	$ 25,000					**$ 25,000**	
4321	Sanchez	Steve		Vendor	$ 25,000	$ 10,000					**$ 10,000**	
3214	Sanchez	Jose		Employee	$ 25,000	$ 7,500	$ 1,000	$ 250	$ 100		**$ 8,850**	
						$ -					**$ -**	
						$ -					**$ -**	
						$ -					**$ -**	
Nursing Services						$ 57,500	$ 9,000	$ 750	$ 400	$ 25,000	**$ 92,650**	To Sch 4A
Delegated Nursing Services												
Trial Balance					$ 100,000	$ 100,000	$ 10,000	$ 1,000	$ 500	25,000	$ 136,500	
Reductions to Trial Balance												
1234	Rodriguez	Robin		Employee	$ 25,000	$ 25,000					**$ 25,000**	
4321	Rodriguez	Rob		Vendor	$ 25,000	$ 10,000					**$ 10,000**	
3214	Rodriguez	Roberto		Employee	$ 25,000	$ 7,500	$ 1,000	$ 250	$ 100		**$ 8,850**	
						$ -					**$ -**	
						$ -					**$ -**	
						$ -					**$ -**	
Delegated Nursing Services						$ 57,500	$ 9,000	$ 750	$ 400	$ 25,000	**$ 92,650**	To Sch 4A
Nutritional Counseling												
Trial Balance					$ 100,000	$ 100,000	$ 10,000	$ 1,000	$ 500	25,000	**136,500**	
Reductions to Trial Balance												
1234	Smithfield	Wells		Employee	$ 25,000	$ 25,000					**$ 25,000**	
4321	Smithfield	Watson		Vendor	$ 25,000	$ 10,000					**$ 10,000**	
3214	Smithfield	Joaquin		Employee	$ 25,000	$ 7,500	$ 1,000	$ 250	$ 100		**$ 8,850**	
						$ -					**$ -**	
						$ -					**$ -**	
						$ -					**$ -**	
Nutritional Counseling						$ 57,500	$ 9,000	$ 750	$ 400	$ 25,000	**$ 92,650**	To Sch 4A

New Mexico Health Care Authority/Medical Assistance Division
CMS School Based Services Cost Report
Other Non-Personnel Direct Medical Cost

Provider Name: **Your NM School District**
Provider Number: **123456789**
Reporting Period End: **6/30/2024**

Schedule 7

Complete Shaded Areas Only

Trial Balance Information			Funding and Percentages (Adjustments)					Trial Balance
Trial Balance Account Number	Account Description	Trial Balance Amount	Is cost fully funded by other Federal funds? Yes or No	IF yes, remove 100%	Is cost partially funded by Federal Funds? Yes or No	Enter Amount of Federal Funded Cost	Other Reductions	Trial Balance Adjusted for Required Amounts to be removed
Direct Medical Supplies, Materials & Other Cost								
Trial Balance		$ 5,000						**$ 5,000**
Reductions to Trial Balance								
1234		$ 1,000	yes	$ 1,000	No			$ 1,000
4321		$ 1,000	no	$ -	Yes	$ 500	$ 100	$ 600
				$ -				$ -
				$ -				$ -

Direct Medical Supplies, Materials & Other Cost **$ 3,400** To Sch 4B

New Mexico Health Care Authority/Medical Assistance Division | **Schedule 8A**

CMS School Based Services Cost Report | **Provider Name:** | **Your NM School District**

Special Education Transportation | **Provider Number:** | **123456789**

Reporting Period End: | **6/30/2024**

Complete Shaded Areas Only

Employee Information						Funding and Percentages (Adjustments)				
Employee ID #	Last Name	First Name	Job Title	Vendor/ Employee	Total Gross Salary	Is position fully funded by other federal grant? Yes or No	If Yes, automatically remove 100%	Is position partially funded by federal funds? Yes or No	Enter Amount of Federal Funded Salary	Other amounts to be removed
Bus Drivers										
Trial Balance					$ 40,000					
Reductions to Trial Balance										
1234	Smith	Jack		Employee	$ 15,000	Yes	$ 15,000			$ -
4321	Jones	Jeff		Vendor	$ 15,000	No	$ -		$ 10,000	$ 2,000
	Subtotal Bus Drivers									
Mechanics										
Trial Balance					$ 40,000					
Reductions to Trial Balance										
1234	Jones	Jim		Employee	$ 15,000	Yes	$ 15,000			$ -
4321	Brown	Joe		Vendor	$ 15,000	No	$ -		$ 10,000	$ 2,000
	Subtotal Mechanics									
Substitute Drivers										
Trial Balance					$ 40,000					
Reductions to Trial Balance										
1234	Turner	Bill		Employee	$ 15,000	Yes	$ 15,000			$ -
4321	Turner	Ben		Vendor	$ 15,000	No	$ -		$ 10,000	$ 2,000
	Subtotal Substitute Drivers									
Bus Monitors/Aides										
Trial Balance					$ 40,000					
Reductions to Trial Balance										
1234	Jackson	Jenny		Employee	$ 15,000	Yes	$ 15,000			$ -
4321	Jackson	Josie		Vendor	$ 15,000	No	$ -		$ 10,000	$ 2,000
	Subtotal Bus Monitors/Aides									
	Total									

Other Transportation Cost Information						Reductions to Trial Balance				
Trial Balance #	Trial Balance Description			Activity Related Only To Specialized Transportation Y/N	Trial Balance Amount	Is this cost funded 100% by other federal fund programs Yes or No	Amount to be removed for other federal funding 100%	Is cost partially funded by other federal grant? Yes or No	If yes in column K, enter dollar amount	Other Reductions - Rebates, Revenues, non-related activities
Other Transportation Cost										
1234	Fuel			N	$ 20,000	Yes	$ 20,000	No		
4321	Repairs & Maintenance			N	$ 20,000	Yes	$ 20,000	No		
3214	Rentals			N	$ 2,000	Yes	$ 2,000	No		
4251	Contract			N	$ 5,000	Yes	$ 5,000	No		
1122	Insurance			N	$ 10,000	Yes	$ 10,000	No		
	Vehicle Depreciation			Y	$ 10,000	Yes	$ 10,000	No		
	Total Other Transportation Costs									

New Mexico Health Care Authority/Medical Assistance Division — **Schedule 8B**
CMS School Based Services Cost Report — **Provider Name:** **Your NM School District**
Special Education Transportation — **Provider Number:** **123456789**
Reporting Period End: **6/30/2024**

Complete Shaded Areas Only

Employee Information						Payroll and Benefits					
Employee ID #	Last Name	First Name	Job Title	Vendor/ Employee	Total Gross Salary	Reductions to Gross Salary	Employee Benefits	Employer- FICA (if not covered under employee benefits)	Medicare Tax - Employer - (if not listed under employee benefits)	Vendor/ Contractor Payments	Salary & Benefits & Vendor Payments
Bus Drivers											
Trial Balance					$ 40,000	$ 40,000	$ 20,000	$ 10,000	$ 5,000	$ 25,000	**$ 100,000**
Reductions to Trial Balance											
1234	Smith	Jack		Employee	$ 15,000	$ 15,000					**$ 15,000**
4321	Jones	Jeff		Vendor	$ 15,000	$ 12,000	$ 750	$ 500	$ 100		**$ 13,350**
	Subtotal Bus Drivers					**$ 13,000**	**$ 19,250**	**$ 9,500**	**$ 4,900**	**$ 25,000**	**$ 71,650**
Mechanics											
Trial Balance					$ 40,000	$ 40,000	$ 20,000	$ 10,000	$ 5,000	$ 25,000	**$ 100,000**
Reductions to Trial Balance											
1234	Jones	Jim		Employee	$ 15,000	$ 15,000					**$ 15,000**
4321	Brown	Joe		Vendor	$ 15,000	$ 12,000	$ 750	$ 500	$ 100		**$ 13,350**
	Subtotal Mechanics					**$ 13,000**	**$ 19,250**	**$ 9,500**	**$ 4,900**	**$ 25,000**	**$ 71,650**
Substitute Drivers											
Trial Balance					$ 40,000	$ 40,000	$ 20,000	$ 10,000	$ 5,000	$ 25,000	**$ 100,000**
Reductions to Trial Balance											
1234	Turner	Bill		Employee	$ 15,000	$ 15,000					**$ 15,000**
4321	Turner	Ben		Vendor	$ 15,000	$ 12,000	$ 750	$ 500	$ 100		**$ 13,350**
	Subtotal Substitute Drivers					**$ 13,000**	**$ 19,250**	**$ 9,500**	**$ 4,900**	**$ 25,000**	**$ 71,650**
Bus Monitors/Aides											
Trial Balance					$ 40,000	$ 40,000	$ 20,000	$ 10,000	$ 5,000	$ 25,000	**$ 100,000**
Reductions to Trial Balance											
1234	Jackson	Jenny		Employee	$ 15,000	$ 15,000					**$ 15,000**
4321	Jackson	Josie		Vendor	$ 15,000	$ 12,000	$ 750	$ 500	$ 100		**$ 13,350**
	Subtotal Bus Monitors/Aides					**$ 13,000**	**$ 19,250**	**$ 9,500**	**$ 4,900**	**$ 25,000**	**$ 71,650**
	Total					**$ 52,000**	**$ 77,000**	**$ 38,000**	**$ 19,600**	**$ 100,000**	**$ 286,600**

Other Transportation Cost Information							
Trial Balance #	Trial Balance Description			Activity Related Only To Specialized Transportation Y/N	Trial Balance Amount	Net costs after Federal, State funding, Adjustments	Total Other Costs
Other Transportation Cost							
1234	Fuel			N	$ 20,000	$ -	**$ -**
4321	Repairs & Maintenance			N	$ 20,000	$ -	**$ -**
3214	Rentals			N	$ 2,000	$ -	**$ -**
4251	Contract			N	$ 5,000	$ -	**$ -**
1122	Insurance			N	$ 10,000	$ -	**$ -**
	Vehicle Depreciation			Y	$ 10,000	$ -	**$ -**
	Total Other Transportation Costs						**Total Other Transportation Cost** **$ -**
							Grand Total **$ 286,600**

New Mexico Health Care Authority/Medical Assistance Division
CMS School Based Services Cost Report
Reconciliation and Settlement

Schedule 9
Provider Name: Your NM School District
Provider Number: 123456789
Reporting Period End: 6/30/2024

Complete Shaded Areas Only

Line	Schedule #	RECONCILIATION & SETTLEMENT		Medicaid Direct Services	
1	Schedule 4A-IEP	Summary of Cost by Discipline for IEP/IFSP Medical Services		$13,830	
2	Schedule 4A No-IEP	Summary of Cost by Discipline for 504/BIP/IHP Medical Services		$20,078	
3	Schedule 4B-IEP	Summary of Other Non-Personnel Medical Cost for IEP/IFSP		$125	
4	Schedule 4C	Summary of Transportation Cost for IEP/IFSP Students		$52,543	
5		Total Certified Public Expenditures (CPE) (to Sch 1)		**$86,576**	
6		Federal Share of Medical Cost (Medical Services+Medical Cost) x FFP)		**$63,858**	
7		Total Medical Claims Paid		**$ 5,000**	
8		**FFP Amount Under / (Due From) Provider**		**$58,858**	

Calculation of FFP Percentage

Federal Fiscal Year (FFY) and State Fiscal Year (SFY) covering Cost Report period	SFY	FFY	FFY	FFY
FFY/SFY Period MM/DD/YYYY	6/30/2024	7/1/2023	10/1/2023	1/1/2024
Months in each period	12	3	3	6
Applicable percentage of FFY	1.00	0.25	0.25	0.50
Medicaid - FFP Medical %	0.7376	0.7576	0.7409	0.7259

Remaining State Share for Cost Report Period	$ 2,500
Final FFP Amount Under / (Due From) Provider Post State Share	**$56,358**

CMS Publication 15-1, Section 2409.1(A)(2)
When providers file a cost report indicating that an overpayment has occurred, **FULL REFUND** is to be remitted with the report to HCA/MAD School Health Office. This refund should be mailed under separate cover to:

Send Via US Mail To:

HCA/Medical Assistance Division
School Health Office
Post Office Box 2348
Santa Fe, NM 87504

Make checks payable to:
NM Health Care Authority