Group Home (GH) – Residential Care Center (RCC)

Provider Cost & Service Report

User Guide

For Rate Year 2025

The Department of Children and Families is an equal opportunity employer and service provider. If you have a disability and need to access services, receive information in an alternate format, or need information translated to another language, please call the [PROGRAM AREA or DIVISION at NUMBER]. Individuals who are deaf, hard of hearing, deaf-blind or speech disabled can use the free Wisconsin Relay Service (WRS) – 711 to contact the department.

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1. Cover tab

Cover Instructions

See detailed "Definitions" tab/sheet for additional information. Please complete all applicable yellow shaded areas. Specific directions are given in red text.

Note: The Cover tab shown here **must** be completed as the **first** step in your cost reporting.

WISCONSIN DEPARTMENT OF CHILDREN AND FAMILIES
PROVIDER COST AND SERVICE REPORT - FOR RATE SETTING YEAR 2024
All Information Submitted Is Considered And Will Be Treated As Proprietary By Wisconsin DCF

Line					
1	FISCAL PERIOD *	FROM		TO	
	* = The fiscal period corresponds to your agency's fiscal year requested.				
2	REPORTING PERIOD **	FROM		TO	
	** = The reporting period corresponds to the period for the financial data being reported in this report.				
3	PARENT ORGANIZATION NAME:				
3a	Organization Service Summary (provide link or attach document)				

The Requested Fiscal Period Is 2022

Line	AGENCY CONTACT INFORMATION			
4	Agency Name:			
5	Agency Contact Name			
6	Mailing Address:			
7	City:		State:	
8	Zip:		E-Mail:	
9	County:		Phone #:	
10				

Line	PROGRAM PROVIDER CONTACT INFORMATION			
11				
12	Program Name:			
13	Program Contact Name			
14	Mailing Address:			
15	City:		State:	
16	Zip:		E-Mail:	
17	County:		Phone #:	

18 (Please Refer To Your Check Stub From Payments Made To You By DCF For Your Provider ID.)

Line								
19	SERVICE PROVIDER ID #							
20	Ceased Operations?		Are Multiple Programs Associated With This ID #?		Private For Profit?		Accredited	
21	Licensed Provider:		New Licensed Applicant?		Urban Pop>50,000?		If Accredited Please Choose One	
22	SERVICE CATEGORY (Choose Only One)						QRTP Certified	
23	RCC							
25	GH							
26	GH Plus							

1. Enter the beginning/ending dates of the fiscal period being reported.

2. Enter the beginning/ending date of the reporting period for your financial data presented (when operating expenses incurred).

3. Enter Parent Organization Name.

4. Enter Service Summary or reference to where summary is located.

5. Enter Agency Contact Information. For smaller organizations, the name may be the same as the parent org name.

6. Enter Program provider contact info. This may be the same as agency contact for smaller organizations.

7. Enter your entity's provider identification number for the reporting program.

8. Indicate if you have multiple programs within the Service Provider ID # reported.

9. Indicate Y / N using the drop-down menus in each line item (Ceased Operations, Licensed Provider, New Licensed Applicant, Private for Profit, Urban Population> 50,000, Accredited, QRTP Provider).

10. Indicate your Service Category using the drop-down menu within the applicable line item.

26	GH Plus	

CERTIFICATION OF ACCURACY - All Cost Reported are Reasonable & Necessary Cost of Services Provided
(Both Sections Must Be Completed)

Person Completing This Form:			Job Title:	
Signature:				
Phone #:		Ext.	Date:	
E-Mail Address:				

Authorized Agency Representative Who Reviewed This Form:			Job Title:	
Signature:				
Phone #:		Ext.	Date:	
E-Mail Address:				

RATE NOTIFICATION LETTER
Please Specify The Individual To Receive The Rate Notification Letter From The Department

Name:			**Job Title:**				
Address:							
City:		**State:**		**Zip:**		**Phone #:**	
E-Mail:							

11. Enter name and contact information for the person that primarily completed the cost report.

12. Once cost report is completed and reviewed, complete your certification of accuracy with the indicated information and sign your certification where indicated.

13. Enter name and contact information that The Rate Notification Letter should be sent to.

2. Verification tab

15. For Single Program Providers, enter your capacity measures as follows:
- Daily Licensed Capacity beds available daily.
- Daily Intended Operating Capacity
- Daily Program Staffing beds available.

14. Automatically completed from data you have entered on the Cover page.

Line		
1	Agency Name:	
2	Service Provider Name:	

Line	CALCULATED OCCUPANCY vs CAPACITY	
3	Licensed Capacity Beds Available Daily	
3a	Intended Operating Capacity (If lower than licensed capacity, provide reasoning in assumptions tab)	
4	Program Staffing Beds Available Daily	
5	Program Staffing Beds Available During The Period	
6	Total Period Placement Days	
7	Average Daily Placements	
8	Occupancy Percentage	
9	Capacity Percentage	

Provider's Current Daily Rate:	

16. For Single Program Providers, enter your current rate you receive for placements.

TOTAL PERIOD PLACEMENT DAYS (Census)	
Out Of State Period Placement Days	
Private Pay & Private Insured Period Placement Days	
Wisconsin Period Placement Days	
Total Period Placement Days	

17. For Single Program Providers, enter your annual placement days for each placement type listed. Total Period Placements will auto-calculate.

COST VERIFICATION (Verifies data entered to entered Financials. Doesn't mean report is accuarate or complete.)

Please Enter Your Total Costs
As Reported On Your Agency's Financial Statements For The Following:

Line	CATEGORY	AMOUNT PER PROVIDERS FINANCIALS	AMOUNT AS REPORTED	VERIFIED
10	Personnel Costs		$0.00	
11	Property & Transportation Costs		$0.00	
12	Program Allowable Consumables Costs		$0.00	
13	Allowable Reserves & Non-Allowable Consumables Costs (For Financial Statement Tie-Out)		$0.00	
14	Program Specific Costs		$0.00	
15	Rounding Adjustment As Needed (This Value Should Be Minimal & Immaterial)		$0.00	
16	TOTAL COSTS	$0.00	$0.00	

If There Are No Costs For A Category Above Please Enter A Zero (0) In The Amount Per Financials Column.

18. Enter your program costs as reported on your financial statements for the indicated cost categories.

19. The "Amount as Reported" fields will be automatically entered as you complete each related Cost Report tab with your financial data.

Note: Use the "Rounding" cell to tie the calculated total to your actual costs if necessary.

Note: For providers with multiple programs, steps 14-17 will not be visible. These will need to be entered for each program on the Programs tab instead.

Note: Properly completed forms will indicate both the word "Verified" and green shading or will be shown as blank.

If the word "Error" appears in any of the verified fields, please review your data entry for accuracy in that category.

3. Prop & Trans tab

Note: For providers with multiple programs consisting of different rates per program, please include only common cost items here (cost that are equally applicable to all programs). Costs specific to individual programs are to be reported on the "Programs" tab / sheet under each identified program.

Line

0A **Agency Name:**

0B **Service Provider Name:**

20. Automatically completed from data you have entered on the cover page.

Line	Program Allowable Cost Items Only	Cost Category	Type	Direct Program Amount
1	**Program Allowable Occupancy Cost Detail**			
A	Mortgage - Interest Only	Plant & Property	Fixed	
B	Rent / Lease	Plant & Property	Fixed	
C	Building Insurance	Plant & Property	Fixed	
D	Utilities (Electric, Gas, Water, Sewer, Trash Removal)	Plant & Property	Semi	
E	Real Estate / Property Taxes	Plant & Property	Fixed	
F	Leasehold / Building Improvements	Plant & Property	Fixed	
G	Repairs & Maintenance - Building Only Non Capitalizable Cost Only	Plant & Property	Semi	
H	Licenses, Permits & Building Inspections	Plant & Property	Fixed	
I	Landscaping & Lawn Care & Snow Removal	Plant & Property	Fixed	
J	Security System	Plant & Property	Fixed	
K	Depreciation - Building Only (Straight Line Method Allowable)	Depreciation	Fixed	
L	Other / Miscellaneous (Specify):	Plant & Property		
M	**Total Program Allowable Occupancy Cost**			

21. **Occupancy**:
Enter the annual dollar amount for each line item listed.

(Total calculates automatically.)

Note: Any amounts entered in the "Other" lines must include a detailed description of the item(s) and Fixed, Semi or Variable must be selected.

2	Program Allowable Travel Cost Detail			
A	Vehicle Purchases - Below $5,000 Each If amount indicated exceeds $5,000 provide a detailed list of purchases.	Transportation	Fixed	
C	Purchased Transportation For Clients (Taxi Fees, Bus Fare, Contracted Services Etc…)	Transportation	Variable	
D	Agency Vehicle Operating & Maintenance Cost (Gas, Oil, Repair, Maint, Etc…)	Transportation	Semi	
E	Agency Vehicle Insurance, License & Registration	Transportation	Fixed	
F	Transportation Lease / Rental	Transportation	Fixed	
G	Staff Mileage Reimbursement	Transportation	Semi	
H	Miles Reimbursed For Staff Mileage Calculation		N/A	
I	Reimbursement Per Mile			
J	Depreciation - Vehicle (Straight Line Method Allowable)	Depreciation	Fixed	
K	Other / Miscellaneous (Specify):	Transportation		
L	Total Program Allowable Travel Cost			
3	Program Allowable Furniture & Equipment Cost Detail			
A	Furniture & Equipment Purchases - Below $5,000 Each If amount indicated exceeds $5,000 provide a detailed list of purchases.	Plant & Property	Fixed	
B	Repairs & Maintenance - Furniture & Equipment Only Non Capitalizable Cost Only	Plant & Property	Semi	
C	Furniture & Equipment Lease / Rental	Plant & Property	Fixed	
D	Furniture & Equipment Insurance	Plant & Property	Fixed	
E	Depreciation - Furniture & Equipment Only (Straight Line Method Allowable)	Depreciation	Fixed	
F	Other / Miscellaneous (Specify):	Plant & Property		
G	Total Program Allowable Furniture & Equipment Cost			
4	Total Program Allowable Property & Transportation			

22. **Travel**:
Enter the annual dollar amount for each line item listed.

(Total calculated automatically.)

Note: For staff mileage, both the mileage reimbursement dollar amount (Line G) and the miles figure (Line H) must be reported or an “Error” will display.

23. **Furniture & Equipment:**

Enter the annual dollar amount for each line item listed.

(Total calculated automatically.)

Note: Any amounts entered in the “Other” lines must include a detailed description of the item(s) and Fixed, Semi or Variable must be selected.

4. Consumables tab

CONSUMABLES - FOR RATE SETTING YEAR 2024

Line		
1	**Agency Name:**	
2	**Service Provider Name:**	

Line	Program Allowable Cost Items	Cost Category	Type	Direct Program Amount
3	Activities / Outings / Recreation For Children	Recreation	Variable	
4	Administrative Allocation - Clarify in Assumptions Tab (Providers With A Parent Entity Pushing Down Costs)	Admin Overhead	Fixed	
5	Administrative Allocation - Clarify in Assumptions Tab (Providers With A Parent Entity Pushing Down Costs)	Admin Overhead	Semi	
6	Administrative Allocation - Clarify in Assumptions Tab (Providers With A Parent Entity Pushing Down Costs)	Admin Overhead	Variable	
7	Advertising / Marketing For Staff Recruitment	Admin Consumables	Fixed	
8	Audit Fees	Admin Consumables	Fixed	
9	Bank / Accounting / Legal Fees	Admin Consumables	Fixed	
10	Children - Allowances/Clothing/Gifts/Incidentals/Personal (	Board	Variable	
15	Contact Services (These Costs Relate To Expenses For Child - Parent Visitations.)	Program	Variable	
16	Employee Screening / Background Checks / Recruitment	Admin Consumables	Fixed	
17	Food & Beverage (Restaurants) (Dietary Supplies)	Board	Variable	
20	Laundry & Housekeeping	Board	Semi	
21	Liability Insurance	Insurance	Fixed	
22	Licenses, Fees & Permits	Admin Consumables	Fixed	
24	Payroll Processing & Benefit Admin Fees	Admin Overhead	Fixed	
25	Postage & Freight	Admin Consumables	Semi	
26	Printing	Admin Consumables	Semi	
27	Professional Dues, Subscriptions, etc...	Admin Consumables	Fixed	
28	Self-Funded Health Insurance Expenses	Admin Overhead	Fixed	
29	Services - Educational (i.e. Tutoring)	Educational	Variable	

Note: For providers with multiple programs consisting of different rates per program, please include only common cost items here (cost that are equally applicable to all programs). Costs specific to individual programs are to be reported on the "Programs" tab / sheet under each identified program.

24. Automatically completed from data you have entered on the Cover tab.

25. **Program Allowable Costs:** Enter the annual dollar amount for each line item listed.

(Total calculated automatically.)

Note: Rows may appear to be missing, but have been removed as they don't apply to your provider type, but we left the line numbers consistent across all provider types.

	Program Allowable Cost Items	Cost Category	Type	Direct Program Amount
30	Services - Health & Dental Needs Assessments / Resourc	Medical	Variable	
31	Services - Household Resources (Janitorial)	Board	Semi	
32	Services - Other Outside (Specify)			
33	Services - Professional	Admin Consumables	Semi	
34	Services - Psychiatric	Therapy	Variable	
35	Services - Purchased Clinical (Speech, Hearing, Occupational & Physical Therapies)	Therapy	Variable	
37	Staff Meals While On Duty	Admin Consumables	Semi	
38	Supplies - Children's School	Educational	Variable	
39	Supplies - Computers & Peripherals	Admin Consumables	Semi	
40	Supplies - Educational	Educational	Variable	
41	Supplies - Health & First Aid (Medical & Drugs)	Medical	Variable	
42	Supplies - Household & Janitorial	Board	Semi	
44	Supplies - Office & Operating	Admin Consumables	Semi	
45	Supplies - Program, Vocational, Recreational, Crafts, Infar	Program	Variable	
46	Telephone / Internet / Cable / Satellite / Pager / Fax	Admin Consumables	Fixed	
47	Training / Development / Conference / Convention Costs	Training	Semi	
48	Worker's Compensation Insurance	Insurance	Semi	
49	Other / Miscellaneous (Specify)			
50	Total Program Allowable Costs			
51	Allowable Reserves / Profit	Admin Overhead	Fixed	

Note: Any amounts entered in the "Other" lines must include a detailed description of the item(s), the appropriate Cost Category must be selected, and the appropriate Cost Type (i.e. Fixed, Semi or Variable) must be selected.

26. **Allowable Reserves /Profit:** Enter the annual dollar amount of your allowable reserves / profit if applicable.

	Non-Allowed Costs (FOR FINANCIAL STATEMENT TIE OUT ONLY)			
52	Advertising, Except Notifications Related To Program Administration	Not Allowed	N/A	
53	Awards And Grants To Individuals	Not Allowed	N/A	
54	Bad Debt Expense (Write-Offs) (Excludes Collection Fees)	Not Allowed	N/A	
55	Compensation To Non-Working Owners & Officers Special Benefits To Owners Not Taxed As Compensation	Not Allowed	N/A	
56	Contingency Funds	Not Allowed	N/A	
57	Development Of Bids Or Proposals	Not Allowed	N/A	
58	Discounts, Rebates, Allowances & Charity Grants Offered By Your Program / Facility	Not Allowed	N/A	
59	Entertainment Expenses	Not Allowed	N/A	
60	Exceptional Payments Made By Counties Above The Current Rate	Not Allowed	N/A	
61	Federal Income Taxes	Not Allowed	N/A	
62	Fines & Penalties	Not Allowed	N/A	
63	Fund-Raising	Not Allowed	N/A	
64	Housing Of Non-Clients (Except Live-In Staff)	Not Allowed	N/A	
65	Individual Memberships To National, State Or Parent Organizations	Not Allowed	N/A	
66	Interest Expense (Other Than For Mortgage, Vehicle & Equipment Loans)	Not Allowed	N/A	
67	Lobbying Or Other Political Activities	Not Allowed	N/A	
68	Mortgage And Loan Principal Payments	Not Allowed	N/A	
69	Non-Allowed Legal Fees (See Definitions)	Not Allowed	N/A	
70	Non-Program Related Activities	Not Allowed	N/A	
71	Related Party Transactions (Amounts Above Fair Market Value)	Not Allowed	N/A	
72	Research Items	Not Allowed	N/A	
73	Revenue-Producing Expenses	Not Allowed	N/A	
74	Severance Pay (Unless Required By Law Or Employee Contract)	Not Allowed	N/A	
75	Staff Meals Not On Duty	Not Allowed	N/A	
76	State Income And Sales Tax If Exemptions Are Available	Not Allowed	N/A	
77	All Other Non-Allowed Costs	Not Allowed	N/A	
78	Unrestricted & Undesignated Gifts & Donations (These Reduce Expenses So Enter As A Negative	Not Allowed	N/A	
79	**Total Non-Allowed Costs**			
80	**Total Costs**			

27. **Non-Allowable Costs:**
Enter the annual dollar amount for each line item listed for non-allowable costs needed to "Tie-out" to your financial statements.

5. Programs tab

28. Automatically completed from data you have entered on the Cover tab.

29. Enter the name of each rate-based program you operate in the individual Columns. Up to 10 are available.

Line				
		Admin Overhead	Insurance	Train
1	**Agency Name:**	Board	Medical	Transpo
2	**Service Provider Name:**	Depreciation	Plant & Property	
	NOTE: THIS FORM IS FOR REPORTING MULTIPLE PROGRAMS UNDER ONE	Educational	Program	
		1	**2**	**3**
3	**PROGRAM NAME**			
14	**Provide Current Program Daily Rates**			
	CALCULATED OCCUPANCY vs CAPACITY			
15	Licensed Capacity Beds Available Daily			
15a	Intended Operating Capacity (If lower than licensed capacity, provide reasoning in assumptions tab)			
16	Program Staffing Beds Available Daily			
17	Program Staffing Beds Available During The Period			
18	Out Of State Period Placement Days			
19	Private Pay & Private Insured Period Placement Days			
20	Wisconsin Period Placement Days			
21	Total Period Placement Days			
22	Average Daily Placements			
23	Occupancy Percentage			
24	Capacity Percentage			
	CURRENT STAFFING RATIOS			

30. Enter your capacity numbers. See Verification tab for more details.

31. Enter your placement numbers. See Verification tab for more details.

CURRENT STAFFING RATIOS			
Direct Care: 1 Staff To # Of Children - Day Time Hours (Non-School Hours)			
Direct Care: 1 Staff To # Of Children - Day Time School Hours			
Direct Care: 1 Staff To # Of Children - Night Time Sleep Hours			
Direct Care: 1 Supervisor To # Of Children - Day Time Hours (Non-School Hours)			
Direct Care: 1 Supervisor To # Of Children - Day Time School Hours			
Direct Care: 1 Supervisor To # Of Children - Night Time Sleep Hours			

32. Enter your Direct Care and Supervisory staffing ratios. See Personnel tab for more details.

33. Enter an expense description for each program specific cost.

34. For each cost line, select an appropriate cost category from the dropdown.

35. For each cost line, select an appropriate cost type (fixed, variable, semi) from the dropdown.

	PROGRAM SPECIFIC COSTS (If Consolidating Lines, Do So By Cost Category And Provide Line Detail On Separate Worksheet)	% Prgm Costs	% Total Costs								
31	Description			Cost Category	Type	Impact	Eligibility	Totals			
32											
33		0.00%	0.00%								
34		0.00%	0.00%								
35		0.00%	0.00%								
36		0.00%	0.00%								
37		0.00%	0.00%								
38		0.00%	0.00%								
39		0.00%	0.00%								

Notes: The form displayed is a shortened representation of the actual form.

This form will only appear if "Multiple Programs" is indicated as Y (Yes) below the Service Provider ID # field of the Cover tab.

36. For each cost line, enter the annual dollar amount for each specific cost line listed.

(Total calculated automatically.)

6. Personnel tab

38. **Direct Care Staff Ratios**
For Single Programs Providers, enter your current number of Staff to Children ratios per day for the following:

- Day Time Non-School Hours
- Day Time School Hours
- Night Time Sleep Hours

Multiple Program Providers will not see this and enter this in the Programs tab for each program. Please see the note for Staffing Ratio Reporting that will appear on this form.

37. Automatically completed from data you have entered on the Cover tab.

WISCONSIN DEPARTMENT OF CHILDREN AND FAMILIES
PERSONNEL - FOR RATE SETTING YEAR 2024

Line		
1	**Agency Name:**	
2	**Service Provider Name:**	
3	NOTES	
4	All Costs Should Be Completed Where Applicable.	
5	All Costs Reflected Should Be **Only For The Employer's Share**.	
6	To Print Please Reset The Print Area By Highlighting The Area, Selecting File - Print Area - Set Print Area.	
7	For Additional Lines begin Typing After Last Row In The Title Column (Column E) And The Rows Will Format Automatically For Up To 1,000 Employee Line Entries.	

NOTE: The reported staffed beds from the Verification tab, the Staffing Ratios and Depattment Direct Care & Supervision selected below should relate to each other to ensure correct entry of the data.
For example if the Direct Staffing Ratio is 1 to 8 and Staffed Beds = 16 then 2 Full Time Equivalent Direct Care staff should be identified below for that shift or approxiamately 4160 hours (2 staff X 2080 hours)

Current Direct Care Staffing Ratios [Resident Care Workers]				Ratios Used For Current Ceiling Rate	% of reported hours to expected hours
Day Time (Non-School Hours)	1 Staff To		Children	FALSE	
Day Time (School Hours)	1 Staff To		Children	FALSE	0%
Night Time (Sleep Hours)	1 Staff To		Children	FALSE	
Current Direct Care Supervisory Ratios [Supervisor]					
Day Time (Non-School Hours)	1 Supervisor To		Children	FALSE	
Day Time (School Hours)	1 Supervisor To		Children	FALSE	0%
Night Time (Sleep Hours)	1 Supervisor To		Children	FALSE	

39. **Direct Care Supervisor Ratios**
For Single Programs Providers, enter your current number of Supervisor to Children ratios per day for the following:

- Day Time Non-School Hours
- Day Time School Hours
- Nighttime Sleep Hours

40. Enter a job title for each position or person you have expenses for. No names should be used. This is a free form field.

41. Select the appropriate department for each position entered from the available dropdown list. See the Jobs tab for a listing of positions available under each department.

42. Select the appropriate primary job category for each position entered from the available dropdown list. See the Jobs tab for a listing of positions available.

Note: This field will not populate until a department is selected.

To 1,000 Employee Line Entries.

	#	Title (No Individual Names)	Department	Primary Job Category (Make Selection From Drop Down List)	(Use This Column For Specific Program Identificatio	Total Wages (Combined For All Organizational Entities)
8						
9	STAFFING					
	POSITION					
10	1					
11	2					

43. For providers that selected 'Y' (yes) for multiple programs on the Cover tab only. Select the appropriate program, if specific to a program) for each position entered from the available dropdown list. If the position applies to all programs, you leave this field blank for the given position.

Note:

- This field populates based on the program names entered in the Programs tab by you.
- This column will be blacked out for providers that selected 'N' for multiple programs on the Cover tab.

44. Enter the Total Wages earned by the position entered. This can be used to connect positions that have split responsibilities between or within multiple programs.

Note: This field is not used in calculating per diems and is for information only.

Note: Blue row for each column will sum the column expenses to provide a check figure

45. Enter wage relate information in the following fields:

- Annual Regular Wages
- Annual Overtime Wages
- Annual Hours worked (includes regular and overtime hours)
- Bonus which is to be stated as a percentage of your “Regular Wages”.

46. For corporate entities that paid bonuses, indicate whether the bonus payments were approved by the Board of Directors.

Have Bonuses Been Approved By The Board Of Directors For Corporate Entities?

$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	
WAGES				PAID TIME OFF Only If NOT Included In Annual Regular Rate				INSURANCE					RETIREMENT			
Annual Regular Wages Paid	Annual Over Time Wages	Annual Hours (Reg & OT)	Bonus As % Of Regular Wages (Answer Question Above)	Annual Vacation	Annual Sick	Annual Other Amount	Annual Other (Specify) (i.e. Maternity, Bereaveme	Annual Health	Annual Dental	Annual Life	Annual ST & LT Disability	Annual AD & D	Annual Pension	Annual IRA Matching	Annual Other (Amount)	Annual Other (Specify) (i.e. Recognition, Longevity

47. Enter annual benefit expenses that were incurred for each position entered as applicable.

Note: For items entered in the “Other” columns, provide a description of the expense to the right.

48. Select the Federal Unemployment Taxing Authority (FUTA) rate for the year being reported or closest rate available.

48a. Enter your State Unemployment Taxing Authority (SUTA) rate for the year being reported.

49. If needed, enter adjustments to the payroll taxes as appropriate to tie out amounts to your audited financials.

Please Enter Your State Unemployment Tax Rate At Cell AC9 Below!

For Fiscal Year - 2022					
Payroll Tax Cut-Offs					
$7,000	$14,000	$147,000	N/A		
Payroll Tax Max Rates					Overall Rounding
6.00%		6.20%	1.45%		
Payroll Tax Adjustments					
					$0.00
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
PAYROLL TAXES				Totals Pre Rounding Allocation	TOTALS
FUTA	SUTA	Social Security	Medicare		

Note: These lines are set to automatically calculate by Excel but can be entered manually to match each record if needed.

50. If necessary, enter an overall rounding/adjustment amount as appropriate to tie out amounts to your audited financials.

Note: This amount will be proportionately allocated to every line in the personnel tab with expenses included.

7. Prior Year Assumptions

51. Automatically completed from data you have entered on the Cover tab.

Note: This should include a listing of all assumptions incorporated from the prior year including during negotiations. Prior year cost report can be requested from DCF if it was not returned to you with built in assumptions.

WISCONSIN DEPARTMENT OF CHILDREN AND FAMILIES
PROVIDER Prior Year ASSUMPTIONS - FOR RATE SETTING YEAR 2024

1 Agency Name:
2 Service Provider Name:

Your Cost & Service Report(s) should reconcile to your annual audit report.

****REQUIRED **** Please copy in your listed assumptions that you submitted with your Prior Year Cost report. (Yellow/Blue Cells only). To the right of each item, please use the drop down to indicate if the assumption was put into place or not. Next to that, please explain if the assumption was NOT implemented. Please provide reasonable detail as to why costs were not incurred or delayed.

Example of items to clarify or add in Detail: Clarify if not reconciled to audit; Extraordinary child specific payments made by counties that should be excluded; breakdown of admin allocation reported on line 4-6 of consumables tab; reported true capacity if not equal to licensed beds; vehicle and or furniture purchases >$5,000; allocation process if multiple programs; profit/reserve; excess revenue/surplus; cost for separate program not included in rate regulation; increases or decreases being realized since reporting year (Do not include health insurance or wage increases which would be adjusted by Cost of Living Adjustment (COLA) in calculation of rate); new expenses for additional programs added; future cost in rate year that will be realized (not COLA related).

$ Amount (If requesting Increase or Decrease to Cost Report)	Enter Clarification for items entered into the cost report such as licensed capacity, allocation among programs, profit/revenue, etc. Enter Description of any $ Amount identified as an increase or decrease in cost	Cost Type	Cost Category	Assumption Implemented?	Approximate Date of Implementation (Month/Year)	Explanation
Prior Year Assumptions from 2022 Cost Report (copy and paste from last year file)		Cost Type	Cost Category	Assumption Implemented?	If Implemented, Approximate Date of Implementation (Month/Year)	Explanation

52. These fields should be entered and generally match what was noted in the prior year cost report including:

- Amount
- Description
- Cost Type

53. Select the appropriate implementation status from the dropdown:

- Yes
- No
- Partially

54. If the assumption was implemented, indicate an approximate period it was implemented (month/year).

55. Available to allow you to provide any necessary explanation that may be necessary.

8. Assumptions tab

56. Automatically completed from data you have entered on the Cover tab.

WISCONSIN DEPARTMENT OF CHILDREN AND FAMILIES
PROVIDER ASSUMPTIONS - FOR RATE SETTING YEAR 2024

Line		
1	Agency Name:	
2	Service Provider Name:	

Your Cost & Service Report(s) should reconcile to your annual audit report.

Use the assumptions tab for providing additional clarification to the cost report or to report increases or decreases in cost. This would include: extraordinary child specific payments made by counties that need to be excluded from the cost report; additional or reduced cost that have been or will be realized since the year being reported on the Cost Report. Additional cost should not be added to the cost report but should be listed in this assumption tab with a detailed description. Additional cost related to the cost of living should not be included on the cost report or in the assumptions tab since a COLA adjustment is already included in the calculation of rates. DCF will review all assumptions and add those cost to the cost report if justified and reasonable. DCF will contact the provider if additional information is needed and will also inform provider of which assumptions were justified and not justified to be added to the cost report.

Example of items to clarify or add in Detail: Clarify if not reconciled to audit; Extraordinary child specific payments made by counties that should be excluded; breakdown of admin allocation reported on line 4-6 of consumables tab; reported true capacity if not equal to licensed beds; vehicle and or furniture purchases >$5,000; allocation process if multiple programs; profit/reserve; excess revenue/surplus; cost for separate program not included in rate regulation; increases or decreases being realized since reporting year (Do not include health insurance or wage increases which would be adjusted by Cost of Living Adjustment (COLA) in calculation of rate); new expenses for additional programs added; future cost in rate year that will be realized (not COLA related).

12	Annual Assumptions for the Next Rate Setting Period				
	Please list all other assumptions of new costs that are not included in your prior year audit, but you are currently or will be incurring in the next year.				
13	$ Amount	Description of Costs	Cost Type	Cost Category	DCF Comments
14					
15					
16					
17					
18					
19					

57. $ Amount is required only if requesting an increase or decrease to the cost report. If providing clarification to the cost report only, no $ Amount.

58. Provide a description of the cost/expense that is to be changed. This can include type of expense, unit cost, hourly wage, etc. This will be used as consideration in building in the cost if approved.

59. Select from the dropdown the type of cost being described. The options are currently personnel or non-personnel.

60. Select from the dropdown the cost category that the cost applies to.

Note: The DCF comments field will document DCFs analysis and, if applicable, where and how the cost was built into the cost report.

Note: Other items may be required to be documented in the Assumptions tab as there is more ability to provide text. These items include:

- Documentation/justification of a lower intended operating capacity from licensed capacity.
- Detailed listing of vehicle and furniture purchases exceeding $5,000.
- Detailed listing of allocations from the consumables tab.
- Any other item of note that does not fit elsewhere in the cost report.