



**Child Placing Agency (CPA)
Provider Cost & Service Report
User Guide**

For Rate Year 2025

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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 maroon 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	<input type="text"/>	TO	<input type="text"/> The Requested Fiscal Period Is 2022
	* = The fiscal period corresponds to your agency's fiscal year requested.				
2	REPORTING PERIOD **	FROM	<input type="text" value="01-01-2022"/>	TO	<input type="text" value="12-31-2022"/>
	** = The reporting period corresponds to the period for the financial data being reported in this report.				
3	PARENT ORGANIZATION NAME: <input type="text"/>				
3a	Organization Service Summary (provide link or attach document) <input type="text"/>				
AGENCY CONTACT INFORMATION					
4	Agency Name: <input type="text"/>				
5	Agency Contact Name: <input type="text"/>				
6	Mailing Address: <input type="text"/>				
7	City:	<input type="text"/>	State:	<input type="text"/>	
8	Zip:	<input type="text"/>	E-Mail:	<input type="text"/>	
9	County:	<input type="text"/>	Phone #:	<input type="text"/>	
PROGRAM PROVIDER CONTACT INFORMATION					
12	Program Name: <input type="text"/>				
13	Program Contact Name: <input type="text"/>				
14	Mailing Address: <input type="text"/>				
15	City:	<input type="text"/>	State:	<input type="text"/>	
16	Zip:	<input type="text"/>	E-Mail:	<input type="text"/>	
17	County:	<input type="text"/>	Phone #:	<input type="text"/>	
[Please Refer To Your Check Stub From Payments Made To You By DCF For Your Provider ID.]					
19	SERVICE PROVIDER ID # <input type="text"/>				
20	Ceased Operations?	<input type="text"/>	Are Multiple Programs Associated With This ID #?	<input type="text"/>	Private For Profit?
21	Licensed Provider:	<input type="text"/>	New Licensed Applicant?	<input type="text"/>	Urban Pop>50,000?
22	SERVICE CATEGORY (Choose Only One)			Accredited	
24	CPA	<input checked="" type="checkbox"/>		If Accredited Please Choose One	
				Q RTP Certified	

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

2. Enter the beginning/endings 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.

10. Indicate your Service Category using the drop-down menu within the applicable line item. CPA has been selected for you already as this version is specific to CPAs only.

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, Q RTP Provider).

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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:	

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.

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:			

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

2. Verification tab

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

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.

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

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

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.

Line

1 Agency Name: _____

2 Service Provider Name: _____

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: _____

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

COST VERIFICATION (Verifies data entered to entered Financials. Doesn't mean report is accurate or complete.)			
Please Enter Your Total Costs			
As Reported On Your Agency's Financial Statements For The Following:			
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.

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:			
	Program Allowable Cost Items Only	Cost Category	Type	Direct Program Amount
1	Program Allowable Occupancy Cost Detail			
A	Mortgage - <i>Interest Only</i>	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 - <i>Building Only</i> <i>Non Capitalizable Cost Only</i>	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 - <i>Building Only</i> (Straight Line Method Allowable)	Depreciation	Fixed	
L	<i>Other / Miscellaneous (Specify):</i>	Plant & Property		
M	Total Program Allowable Occupancy Cost			

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

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 <i>If amount indicated exceeds \$5,000 provide a detailed list of purchases.</i>	Transportation	Fixed	
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 <i>If amount indicated exceeds \$5,000 provide a detailed list of purchases.</i>	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

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.

WISCONSIN DEPARTMENT OF CHILDREN AND FAMILIES CONSUMABLES - FOR RATE SETTING YEAR 2024				
1	Agency Name:			
2	Service Provider Name:			
	Program Allowable Cost Items	Cost Category	Type	Direct Program Amount
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	
16	Employee Screening / Background Checks / Recruitment	Admin Consumables	Fixed	
18	Foster Parent Recruitment & Training	FP Training	Semi	
19	Foster Parent Respite	FP Respite	Variable	
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	
32	Services - Other Outside (Specify):			
33	Services - Professional	Admin Consumables	Semi	
39	Supplies - Computers & Peripherals	Admin Consumables	Semi	
44	Supplies - Office & Operating	Admin Consumables	Semi	
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	

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.

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) <i>(Excludes Collection Fees)</i>	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 <i>(Except Live-In Staff)</i>	Not Allowed	N/A	
65	Individual Memberships To National, State Or Parent Organizations	Not Allowed	N/A	
66	Interest Expense <i>(Other Than For Mortgage, Vehicle & Equipment Loans)</i>	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 <i>(Amounts Above Fair Market Value)</i>	Not Allowed	N/A	
72	Research Items	Not Allowed	N/A	
73	Revenue-Producing Expenses	Not Allowed	N/A	
74	Severance Pay <i>(Unless Required By Law Or Employee Contract)</i>	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 <i>(These Reduce Expenses So Enter As A Negative)</i>	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.

(Total calculated automatically.)

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
		Board	Medical	Transpo
		Depreciation	Plant & Property	
		Educational	Program	
		1	2	3
1	Agency Name:			
2	Service Provider Name:			
NOTE: THIS FORM IS FOR REPORTING MULTIPLE PROGRAMS UNDER ONE				
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				
25	Case Management: 1 Staff To # Of Children			
28	Supervision of Case Management: 1 Supervisor To # Of Children			

32. Enter your Case Management and Supervision of Case Management 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)										
	Description	% Prgm Costs	% Total Costs	Cost Category	Type	Impact	Eligibility	Totals		
31										
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

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

38. Case Management Staff Ratios

For Single Programs Providers, enter your current number of Staff to Children ratios per day.

Multiple Program Providers will not see this and enter this in the Programs tab for each program.

Note: Case Management will calculate the rate based on 1.5 shifts to account for on-call/off-hour time based on the ratio entered.

WISCONSIN DEPARTMENT OF CHILDREN AND FAMILIES PERSONNEL - FOR RATE SETTING YEAR 2024				NOTE: The reported staffed beds from the Verification tab, the Staffing Ratios and Department 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 approximately 4160 hours (2 staff X 2080 hours)		Ratio Used For Current Ceiling Rate	% of reported hours to expected hours
Line				Current Case Management Staffing Ratios (Case Managers)			
1	Agency Name:			1 Staff To	Children	9	
2	Service Provider Name:						0%
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.						
				Current Case Management Supervisory Ratios (Supervisor)			
				1 Supervisor To	Children	35	
							0%

39. Supervision of Case Management Ratios
For Single Program Providers, enter your current number of Supervisor to Children ratios per day.

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

8		STAFFING				
9		POSITION				
	#	Title <i>(No Individual Names)</i>	Department	Primary Job Category <i>(Make Selection From Drop Down List)</i>	(Use This Column For Specific Program Identificati Identificati	Total Wages <i>(Combined For All Organizational Entities)</i>
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	\$0.00	
WAGES				PAID TIME OFF <small>Only if NOT Included in Annual Regular Rate</small>				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 Bereavement))	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.

48. 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					
6.00%		6.20%	1.45%		
Payroll Tax Adjustments					
\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
PAYROLL TAXES				Totals Pre Rounding Allocation	TOTALS
FUTA	SUTA	Social Security	Medicare		

Overall Rounding
\$0.00

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.

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: _____

Line 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).

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.				
\$ Amount	Description of Costs	Cost Type	Cost Category	DCF Comments

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.