



WISCONSIN DEPARTMENT
of HEALTH SERVICES

Comprehensive Community Services (CCS) Instruction Manual

Cost Reporting Year 2014

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I – Introduction to the 2014 CCS Cost Reporting Manual

Comprehensive Community Services (CCS) is a behavioral health care program that provides a flexible array of individualized community based psychosocial rehabilitation services to youth and adults. The Wisconsin 2013-15 Biennial Budget (Wisconsin Act 20) authorized the Department of Health Services to increase funding for CCS to promote program regionalization among county and tribal program participants. As a result, effective for dates of service on and after July 1, 2014, ForwardHealth will provide reimbursement for both the federal and non-federal share of Medicaid and BadgerCare Plus funding for allowable program costs to counties and tribes certified as regional CCS programs.

Along with Wisconsin Act 20 changes to the CCS program, the Department of Health Services (DHS) implemented a number of policy changes to improve interim claim transparency, as well as provide necessary claim detail to allow for cost reporting within regional models. Additionally, clarifications were made regarding allowable services in the CCS service array. A ForwardHealth Provider Update was issued in June 2014 providing details on CCS policy changes effective for dates of service on or after July 1, 2014: <https://www.forwardhealth.wi.gov/kw/pdf/2014-42.pdf>

This manual provides an overview of the cost reporting methodology for the 2014 calendar year. Two distinct cost reporting methodologies are addressed in order to respectively handle dates of service prior to the program changes effective July 1, 2014 and dates of service subsequent to this effective date. For dates of service **between January 1, 2014 and June 30, 2014**, counties with established CCS programs will continue to use the cost reporting methodology of prior calendar years. For dates of service **on July 1, 2014 and after**, established CCS programs and newly certified CCS regional programs will use an updated cost reporting spreadsheet that incorporates the policy changes authorized under Wisconsin Act 20.

Each CCS reporting entity will complete one 2014 CCS excel-based report which will collect cost report data for the period from January 1, 2014 to June 30, 2014 under the legacy reporting methodology and a cost report for the period from July 1, 2014 to December 31, 2014 under the updated reporting methodology. Completed 2014 CCS reports will be submitted as an email attachment to PCG at wiccs@pcgus.com on or before the deadline for 2014 cost report completion.

CCS Cost Reconciliation Timeline

For CCS programs established prior to January 1, 2014, two separate cost reconciliations will be required for calendar year 2014 dates of service – one for the January through June 2014 period, and another for the July through December 2014 period. All CCS programs will be required to use the updated cost reporting and reconciliation process for dates of service on and after July 1, 2014, regardless of whether the CCS program has joined an established CCS region. All cost reporting for calendar year 2014 will occur after the close of the calendar year. Note that to provide a more efficient cost reporting process in the future, CCS regions may only make changes to their respective regional models or the region's member counties once during the 2015 calendar year, and only at the start of each calendar year, beginning with calendar year 2016. This transition period will eventually provide for a singular cost reporting period for all counties based on the calendar year.

Significant Financial Clarifications and Changes

With Act 20 authorizing additional funding for CCS regional programs, DHS implemented a number of policy changes, including many with significant financial implications. Below describes the most significant financial changes and other financial clarifications affecting all CCS programs, regardless of regionalization, for dates of service on and after July 1, 2014:

Interim Billing Principles:

Wisconsin Administrative Code continues to require the following primary criteria for CCS billing, regardless of service environment:

- The service must be included in the CCS Program Service Array found in Attachment 1 of *Update 2014-42*.
- The service must be attributed to a specific CCS member.
- The service must be authorized as part of the member's service record and documented as required by DHS Chapter 36, Wisconsin Administrative Code.

Additionally, the same billing principles apply to billing for both individual and group services. In order for a CCS provider to bill for a group service, the provider must satisfy the criteria above while providing a service to at least two consumers simultaneously. As with individual services, the group service must be documented in the service record of each consumer that received the group service.

New Procedure Code:

Effective for dates of service on and after July 1, 2014, CCS programs are required to submit all CCS claims under Healthcare Common Procedure Coding System procedure code H2017 (Psychosocial rehabilitation services, reported to the nearest 15 minute unit of service) for all service delivery time and documentation time, including services provided in a residential setting. Prior to July 1, 2014 dates of service, CCS programs were required to use procedure code H2018 (Psychosocial rehabilitation services, per diem). The per diem procedure code (H2018) will be replaced with the time unit based procedure code (H2017) for all claims including residential billing. Any claims that use the per diem procedure code for dates of service on or after July 1, 2014 will be denied.

Claim Structure:

Effective for dates of service on and after July 1, 2014, interim claims must include modifiers to provide additional information on the claim. CCS programs must denote the appropriate professional provider type in the first modifier position and indicate whether the service was provided as an individual or group service in the second modifier position.

Statewide Interim Rates:

Prior to July 1, 2014 dates of service, established CCS programs were required to justify county-specific interim CCS payment rates for DHS on an annual basis. CCS programs were required to receive interim payment rate approval from DHS prior to the program billing for interim claims. This process was often

time-consuming and sometimes led to a delay in interim claim billing for many months into the calendar year.

Beginning with dates of service on and after July 1, 2014, CCS Program-specific payment rates have been replaced with statewide payment rates for interim claims payments. All CCS programs, regardless of regionalization, will be subject to the same payment rates for reimbursement on interim claims. Statewide payment rates help eliminate the requirement for CCS programs to justify interim rates with DHS and will allow programs to bill interim claims without the need to receive rate approval. Note that, given the variance in allowable program costs, the transition to a statewide interim payment rate in practice means a CCS Program's cost reconciliation will have more financial significance for realizing full reimbursement for allowable CCS costs. Also note that programs should continue to bill Medicaid their actual cost per unit of service regardless of established statewide payment rates. This will help guard against overstating interim claim costs that require financial recoupments from counties through the reconciliation process.

Residential Services Interim Billing:

Prior to July 1, 2014 dates of service, residential services were billed on a per diem basis. Starting with dates of service on and after July 1, 2014, billing will transition to incremental time unit based billing, which will require CCS programs to bill for services within a residential setting based on units of service rounded to the nearest 15-minute increment.

The transition from per diem to per unit billing aims to improve the transparency of interim claim submission and the accuracy of the cost reconciliation process. The previous cost reporting method lacked the sufficient cost detail necessary to justify all program costs. In transitioning from per diem billing to time unit billing, CCS programs will be expected to document direct services provided to CCS members throughout the day. Based on this documentation, programs must distinguish between individual rate and group rate services provided to members in a residential setting.

For example, if a residential program staff member provides Skill Development and Enhancement to a CCS member individually and also as part of a group of two or more CCS residents, the service provider would document the following in the member's service record:

- The length of time the CCS services were provided to the member individually.
- The length of time the CCS services were provided to the member in a group setting.

Billing for these services must conform to the criteria listed in the interim billing principles section above.

Additionally, see the separate "[Comprehensive Community Services \(CCS\) Residential Rate Setting Guidance](#)" document for more details regarding billing for services in a residential setting. The guidance document provides information on establishing an individual and group billing rate, reimbursement of residential services costs, and appropriately documenting individual and group residential services. It also provides a sample residential rate setting method that may be used for reference.

Cost Reimbursement:

As in past cost reporting years, CCS programs will continue to cost reconcile in order to fully reimburse for allowable Medicaid costs after the close of each calendar year. This reconciliation will result in either a financial payment to, or recoupment from, the CCS program based on a comparison of allowable Medicaid costs and interim financial payments made for the period.

For dates of service prior to July 1, 2014, the state provided reimbursement for the federal share of CCS program costs, while the counties provided the local matching funds. Effective for dates of service on and after July 1, 2014, the state will provide reimbursement for both the federal share and state share of CCS program costs – a total of 100 percent of allowable Medicaid costs for any county or tribe that joins a certified CCS region. Regardless of the number of units billed, the cost-settlement process will not result in payment in excess of total allowable program costs.

Note that for counties or tribes that are not participating in a certified region, the state will continue to pay only the federal share of CCS program costs.

Cost Category Terminology Shift:

Beginning with dates of service on and after July 1, 2014, the **Indirect Cost** category used in the prior, or “legacy,” cost reporting method will transition to a category called **Direct Support Costs**.

Prior to July 1, 2014 dates of service, indirect costs were defined as the salary and benefits of indirect service staff, which included CCS administrators, supervisors, and clerical workers whose primary function included management, coordination, or office support of the CCS program, but not necessarily direct support services. Indirect costs also included **Other Indirect (Non-Staff) Costs**, which consisted of non-staff overhead costs such as material and supply costs or facility costs.

For dates of service on and after July 1, 2014, all costs directly related to CCS program operation will be considered **Direct Costs**, which will consist of the subcategories **Direct Service Costs** and **Direct Support Costs**. **Direct Service Costs** consist of the costs reported on interim claims, including service delivery time, provider travel time, and documentation time. **Direct Support Costs** include all hours spent on the CCS program aside from CCS direct hours. Examples of direct support hours include a supervisor’s time supervising CCS staff, the CCS administrator’s time spent on general CCS administration, and staff training time directly related to CCS.

Non-staff costs from the prior legacy method will now be captured in **General Admin and Overhead Costs**. These costs reflect central services related to overall agency operations that are allocable to all agency programs including CCS. Examples of general overhead costs include accounting, billing, financial, human resources, legal, plant maintenance, software, lease and rental, and utility costs.

Note that any costs incurred for dates of service prior to July 1, 2014 should not be included in the new cost reporting methodology used for dates of service on and after July 1, 2014.

II - General Rules for CCS Reporting

Format for CCS Cost Reporting

Dates of service prior to July 1, 2014

The 2014 CCS cost reporting spreadsheet will include a tab for dates of service prior to July 1, 2014 to collect cost information from counties. CCS programs established prior to January 1, 2014 have used this spreadsheet for cost reporting in previous calendar years. The spreadsheet will also be used by the State to perform reviews for cost reasonableness for January 2014 through June 2014 costs. Each CCS program will be provided with a cost reporting spreadsheet that includes that county's approved interim rates for January through June 2014.

As in prior calendar years, the cost reporting spreadsheet will include audit checks that CCS Programs are required to respond to if triggered. To expedite the review process, CCS programs should validate their data when a review question is triggered in the spreadsheet. Once the CCS program confirms that the entered data are accurate, they should provide an explanation for why their costs have exceeded the expected threshold.

For dates of service prior to July 1, 2014, no cost information by provided CCS services is collected for county staff. County staff information is collected by professional type. For contracted staff and vendors, cost information is collected by CCS services provided, but no information on the professional level of contracted staff is collected as part of the cost reporting spreadsheet.

Dates of service on and after July 1, 2014

For dates of service on and after July 1, 2014, the CCS Cost Reporting process will continue to use a spreadsheet to collect cost information from CCS programs, though the spreadsheet will have a new format to accommodate the regional models as well as the other financial changes effective July 1, 2014. The information collected in the new cost reporting spreadsheet will again allow DHS to perform cost reasonableness checks. Each CCS program will be provided with the cost reporting spreadsheet that includes the CCS statewide interim payment rates as well as the claims submitted by the program.

Each region must report disaggregated regional costs by reporting cost at the county or tribe level. A regional summary will be constructed through spreadsheet output representing the summation of county and/or tribal costs at the regional level.

For dates of service beginning July 1, 2014, the CCS cost reporting process will begin to use a method consistent with the WIMCR cost reporting process, including methods for allocating general overhead costs and collection of cost and personnel information as described in Section V below.

Under the new CCS cost reporting methodology, cost information will be collected by professional type for both county staff and contracted staff. No information on the CCS service provided will be collected. Although CCS service information is not currently captured on the interim claims, information on the

service provided and how the service relates to the member's service plan should be documented in the member's medical record.

The cost reporting spreadsheet will continue to include desk review checks, which CCS programs must respond to if triggered. The desk review checks will be consistent with those used for the WIMCR cost reporting process. To expedite the desk review process, CCS programs should validate their data when a desk review question is triggered in the spreadsheet. Once the CCS program confirms that the entered data are accurate, they should provide an explanation for why their costs have exceeded the expected threshold.

Aligning Direct Costs and Interim Claims

Regions must align a county's direct costs and interim claims units. This means that a county must be shown as the rendering provider for interim claim units if the county would like to include those direct costs on their cost report. For proper reconciliation, alignment of direct costs and billed units within a county on a cost report is required. **A county cannot report direct costs without billed service units from interim claims.**

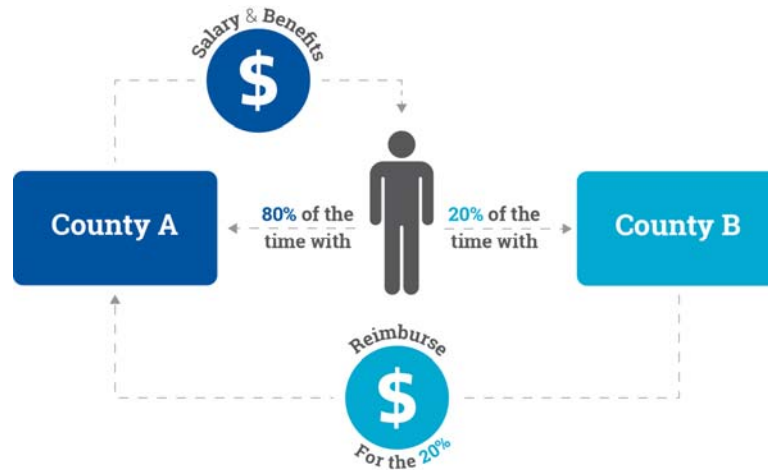
Reporting Intergovernmental Agreement Revenues and Expenses

Counties have the flexibility to enter into contractual arrangements for service provision either among regional county entities or with non-county contractors. Additionally, a region may contract with a county outside of the region for services. This outside county would be treated as a subcontractor and would not have a county section on the cost report.

If counties or tribes opt to contract with other counties or tribes within their region, each must report the appropriate revenues and expenditures to avoid double-counting costs. The county or tribe employing all shared staff will report total salary and benefits paid to each shared employee, as well as a revenue offset for all contract revenue received from another county or tribe for services provided by the regional shared employee. Similarly, the county or tribe employing all shared staff should report total hours (direct service) or FTEs (overhead) as well as an offset for hours worked on behalf of another reporting entity.

Intergovernmental Agreements Terminology

- **Intergovernmental Agreements:** An intergovernmental agreement occurs when an employee of one county or tribal reporting entity provides services on behalf of a second reporting entity and the second reporting entity reimburses the first reporting entity for services provided. The graphic below shows an example intergovernmental agreement.



- **Regional Shared:** The term regional shared is used to identify an individual or a category of overhead used to support multiple counties.
- **Revenue Offset:** A revenue offset is the dollar amount paid from one county to another for services provided by a regional shared clinician or overhead provider.

An example of a regional shared direct service clinician is outlined within the [Direct Service and Support](#) section. An additional example of a shared Overhead provider is outlined within the [General Overhead Costs](#) section.

Introduction to CCS 2014 Reporting (Sections III – V)

The next three sections of the CCS Instruction Manual will describe each required reporting component for 2014 CCS reports including screenshots and descriptions of all data fields. Data entry fields described in subsequent sections below align with sections and tabs within the 2014 excel based report.

Below is a brief description of each section:

- **III – Reporting General and Regional Information:** This section outlines the general information and regional information sections of the report. These sections are applicable to the entire 2014 calendar year (January 1, 2014 – December 31, 2014).
- **IV - Cost Reporting for Dates of Service Prior to July 1, 2014:** This section references the legacy CCS reporting methodology and provides a link to more in depth guidance applicable to the legacy CCS reporting period (January 1, 2014 – June 30, 2014).
- **V - Cost Reporting for Dates of Service on and after July 1, 2014:** This section provides detailed guidelines for the updated CCS reporting period (July 1, 2014 – December, 2014).

III – Reporting General and Regional Information

Report List Item: General Information Reporting Guidelines

Agency Information	
Agency	
NPI Number(s)	
County(s)	
Agency Type	
Address	
Billing Provider ID	
Rendering Provider ID (if different from billing provider ID)	

- Enter the Agency name (e.g. Demo County Department of Health and Human Services)
- Enter all certified NPI numbers associated with the reporting entity.
- Enter all applicable counties (e.g. Demo County)
- Enter the provider mailing address
- Enter Billing and Rendering Provider ID(s), see call-out box below for additional clarification.

Billing vs. Rendering Provider IDs

Each cost report should correspond to a single unique rendering provider ID. No two reports should share a rendering provider ID.

Each interim claim submitted must include a billing provider and rendering provider. A **billing provider** is the billing entity (county or tribe) that submits the interim claim. A **rendering provider** is the entity that rendered the service.

A rendering provider can also be thought of as “**rendering via contract.**” In this case, the rendering provider would reflect the county or tribe that has paid the contracted service (either a contract with another county’s staff person or a contract with a vendor). The billing and rendering provider numbers will be used to assign interim claims to counties for cost reporting and reconciliation purposes.

A county or tribe must be the rendering provider on the interim claims if they want to report those direct service units and associated costs. The rendering via contract concept can be used to align direct service units with costs when contracts include sharing county staff. If one county in a shared services region intends to complete all billing on behalf of counties in the region, then that county should act as a “**third party biller**” and use their own billing provider ID and rendering provider numbers for the county that incurred the cost.

Contact Information

Contact information is required in case of any follow up questions stemming from data reported. Feel free to include contact information for more than one individual working on cost report completion.

Contact Information for Individual Completing Report	
First and Last Name	
Phone Number	
Email Address	

Report List Item: Regional Information Reporting Guidelines

Are you participating in a CCS region?

Question	Agency Response
Did you participate in a CCS regional model during the reporting period?	☐ Yes ☐ No

- Answer yes if your CCS program was certified to provide services as a CCS regional program between July 1, 2014 and December 31, 2014.

Regional Characteristics

Additional Questions for Regional Participants (as of 12/31/14)	Agency Response
Name of Region	
Regional Certification Number	
Type of Region	<i>Please Select</i>
Lead County (if applicable - required for multi county region)	<i>Please Select</i>
Additional Counties (if applicable - required for shared services and multi-county regions)	

- Enter the name of your CCS regional program as certified by DQA.
- Enter the Regional Certification Number of your CCS regional program as certified by DQA.
- Select your regional type: Population-based, Shared Services, Multi-County, or 51.42.
- If you are a Multi-County region, please denote the lead county.
- List all counties that are participating in your region.

In order to receive reimbursement for interim claims and to improve the accuracy of cost reporting, CCS programs must follow specific cost reporting guidelines based on their regional model type. Below is an overview of four allowable CCS regional models:

Population Based Region (single cost report)

Counties and tribes certified as a population based region should enter totals on their cost report only for their county or tribal agency. Only one cost report will be submitted. For interim claim purposes, the county or tribe will be both billing and rendering provider. If a population based region decides to contract with a county outside of its region, then the outside county would be treated as a subcontractor. The costs should be included in the contract cost sections of the cost report.

Shared Services Region (multiple cost reports)

Counties and tribes certified as a shared services region will each submit their own cost report, but should coordinate with the other counties within the region to ensure that no duplicated costs are included in the report. The information reported in the “Regional Information” section should be consistent across all counties within a region.

For interim claim purposes, each county or tribe in the region will be both a billing and rendering provider. Each county in the region is required to bill Medicaid separately with the county or tribe’s billing and rendering provider numbers. The rendering provider number should only be submitted on claims for which direct costs were incurred by the county or tribe.

Multi-County Region (multiple cost reports)

Counties and tribes certified as a multi-county region will each submit their own cost report, but should coordinate with the other counties within the region to ensure that no duplicated costs are included in the report. The information reported in the “Regional Information” section should be consistent across all counties within a region.

For interim claim purposes, the region’s lead county or tribe should be listed as the billing provider on all interim claims, while the rendering provider number on the claim should indicate the rendering county or tribe that incurred the cost.

Cost report completion for counties within a multi-county region may be completed by individuals within each county. Alternately, a single regional representative from the lead county can complete individual reports for other counties within the region. Each county is required to review and validate cost report data compiled on their behalf by the lead county prior to submitting completed cost report data.

51.42 Region (single cost report)

Counties and tribes certified as a 51.42 region should include total costs of all FTEs employed by the 51.42 entity and all expenditures incurred by the 51.42 entity. Interdepartmental charges may include charges from counties in their region for various “central services” costs. Only one cost report will be submitted. For interim claim purposes, the 51.42 legal entity should be listed as the billing rendering provider on all claims.

Regional Timeline

Region History	Agency Response
Date of initial formation of region	
Has regional county participation or region type altered since the region was initially formed?	☒ Yes ☐ No
Date of change	
Narrative Description of Change	

- Enter your regional certification date provided to you by DQA.
- (If applicable) enter the date and description of any changes to your regional structure subsequent to your original DQA certification date.

IV - Cost Reporting for Dates of Service Prior to July 1, 2014

Cost reporting for dates of service from January 1, 2014 to June 30, 2014 will apply the principals of legacy CCS reporting. [Click here to access guidance documentation for legacy CCS reporting.](#)

V - Cost Reporting for Dates of Service on and after July 1, 2014

The cost reporting tab for dates of service on and after July 1, 2014 will reflect the CCS policy changes made after Act 20. The spreadsheet is designed to be consistent with the WIMCR cost reporting process for 2013 calendar year dates of service. CCS programs must submit data in six separate sections: County Agency Overview, Direct Service and Support, Direct Service Non Personnel, Group Services (if program provides group services) Overhead, and Federal Funds and Reductions.

Report List Item: Reporting Agency Overview

The County Agency Overview captures the total FTEs and costs related to those FTEs on a reporting agency or region-wide basis. Please note that total FTEs and costs should only reflect the cost reporting period. The cost reporting period begins on July 1, 2014 and ends on December 31, 2014. When completing the County Agency Overview section of the cost reporting spreadsheet, the following regional guidelines should be used:

- Population-based, 51.42, shared services regions, multi-county regions and non-region programs should report employees and costs based on agency totals.
- Totals should reflect only the reporting entity and not the entire region.

Enter the following information in the County Agency Overview section:

Total Agency FTEs (mandatory field):

Enter the total number of FTEs as reflected on the reporting agency payroll within the cost reporting period. Note that this includes FTEs that have little or no involvement in CCS programs.

- 1 FTE is equal to 40 hours per week and 2,080 hours per year (1040 hours per six months).

- Total FTEs should include CCS clinicians, other program clinicians and overhead staff

Total Reporting Agency Contracted FTEs to which agency allocates overhead (optional field):

Enter the total number of FTEs providing services via a contractual arrangement to which the agency allocates overhead costs within the cost reporting period. Note that this includes contracted FTEs that have little or no involvement in CCS programs.

County Agency Overview - Desk Audit Reviews:

CCS costs should not exceed total costs of the County Agency, Tribal Agency, or Region.

Total cost per FTE is unusually low

Total agency/region wide cost divided by total reported FTEs falls below the expected threshold.

- 1 FTE is equal to 40 hours per week and 2,080 hours per year (1040 hours per six months).
- Total FTEs should include CCS clinicians, other program clinicians and overhead staff

Total Annual Reporting Agency Personnel Expenditures (mandatory field):

Enter gross agency-wide salary and benefit cost within the cost reporting period. Total payroll expenditures should be related to the Total Agency FTEs reported previously.

Total Annual Reporting Agency Operation Expenditures (mandatory field):

Enter all non-personnel costs relating to day-to-day agency operations including contract cost, building cost and materials and supplies within the cost reporting period. As new programs are developed and new regional structures are created, it is expected that total annual agency operation expenditures will increase. The anticipated spike in total annual agency operation cost is consistent with federally allowable cost settlement guidelines.

Interdepartmental Charges (mandatory field):

Report the lump sum portion of agency-wide overhead cost allocated to a particular agency within the cost reporting period.

Below is a sample completed County Agency Overview section of the cost reporting spreadsheet:

County Agency Overview (reflects agency wide cost and FTE information)

Total FTEs (Based upon 40 Average Standard Weekly Hours)	
Total Agency FTEs	3.00
Total Contracted FTEs (to which agency allocates overhead)	5.00
Total	8.00
County Agency Data	
Total Annual Agency Personnel Expenditures	\$ 500,000.00
Total Annual Agency Operation Expenditures	\$ 405,000.00
Interdepartmental Charges	\$ 21,000.00
Total	\$ 926,000.00

Report List Item: Direct Service and Support

Direct costs represent program staffing for client services and program support within the cost reporting period. Direct support costs are incurred by CCS providers for employees that are focused on providing direct support for the CCS program, but do not provide CCS direct services. Consistent with the definition of direct support in WIMCR cost reporting, direct support services in CCS include CCS program supervision, CCS planning and coordination, CCS administration, and CCS clerical support. Direct Service and Direct Support Cost will be reported on the “Direct Service and Support” page.

1. **Professional Type Basic Information:** Enter the following Information for each clinician providing CCS services:
 - **Professional type of the clinician (mandatory).** CCS providers should use the drop down option to choose the most appropriate professional type for each individual clinician. A list of appropriate professional provider types may be found in Attachment 4 of the [ForwardHealth provider update](#). “Direct Support Only” has been included as well for individuals that support CCS program operations without providing a CCS direct service (e.g. CCS supervisors and clerical workers).
 - **First and Last names (mandatory).** Enter the name of the clinician that corresponds to the professional provider type chosen in the previous field. The name entered should match the staff name as shown on the agency’s payroll (e.g., if agency payroll shows a first name of Steven, then the cost report should show Steven and not Steve). Ensuring consistent names will avoid confusion in the event of an audit.
 - **County job title (Mandatory if Direct Support Only).** Indicate the staff member’s job title according to county records.
 - **National Provider ID (NPI) (optional, mandatory for regional shared clinicians with NPIs).** Report the unique 10-digit number assigned to an individual clinician. (Note that not all CCS providers will have an NPI.)

- **Employment Status (mandatory).** Use the drop down option to designate the clinician as agency employee, contractor, agency employee – regional shared, contractor – regional shared. If either of the “regional shared” designations are selected, provider NPI is a mandatory field when applicable.
- **Allocate Overhead Cost (mandatory).** Use the drop down option to indicate whether or not overhead costs will be allocated to each professional. Note that it is expected that overhead be allocated to agency staff, while the CCS program should indicate for each contracted clinician if overhead should be allocated.

Below is an example of a completed **Professional Type Basic Information** section of cost reporting spreadsheet:

Basic Information						
Last Name	First Name	Professional Type	Job Title (Optional Unless Direct Support)	NPI (Optional Unless regional shared)	Employment Status	Allocate Overhead (yes if Agency Employee)
John	Lennon	Bachelors Degree Level			Agency Employee	Yes
Paul	McCartney	Psychiatrist/MD		111111111	Agency Employee - Regional Shared	Yes

2. **Professional Type Cost July 1 through December 31:** Cost information for each clinician that provided CCS services will be collected in this section. The professional type, first name, and last name of each clinician will be prepopulated based on information entered under the Professional Type Basic Information section. Information to be collected includes:

- **Salary.** Enter the gross salary amount paid to any CCS staff identified as an agency employee. Consistent with WIMCR cost reporting, the amount reported in this field should be inclusive of all cost from which payroll taxes are deducted, including regular wages or extra pay, paid time off (e.g., sick or annual leave), overtime, bonuses or longevity, stipends, and cash bonuses and/or cash incentives. Reimbursements for expenses such as mileage or other travel reimbursements should not be included in this field. Salary should reflect only cost incurred from July, 1 2014 – December 31, 2014.

- Benefits.** Enter the total benefits paid to any CCS staff identified as an agency employee. Consistent with WIMCR cost reporting policies, the benefits field should include employer-paid health/medical, life, disability, or dental insurance premiums, as well as employer-paid child day care for children of employees paid as employee benefits on behalf of your staff, retirement contributions, and worker's compensation costs. Report the expended amounts paid by the county agency which are directly associated with each staff member by type of employee benefit. Employee benefits include: employee insurance, social security contributions, state retirement system contributions, tuition reimbursement, unemployment insurance, workers' compensation, other employer paid health benefits, other employer paid employee benefits. Benefits should reflect only cost incurred from July, 1 2014 – December 31, 2014.
- Contract Costs.** Enter any costs incurred for the purchase of CCS professional services provided by contractor staff. Consistent with WIMCR cost reporting, the reported contract costs should be the total costs for the agency or individual as paid by the county agency for the reporting period. Contract cost should reflect only cost incurred from July, 1 2014 – December 31, 2014.
- Total Costs (prepopulated).** For county and tribe staff members, this field will represent the sum of salary and benefits. For contractors, this field will represent the reported contract cost.
- Regional Revenue Offset.** This field will represent the sum received by the reporting entity from other counties in the region for services provided by the designated county or tribe clinician.
- Net Costs (prepopulated).** For county and tribe staff members, this field will represent the Total Costs net of all Regional Revenue Offsets.

Professional Type Cost - Desk Audit Reviews:

Salary or benefits are unusually high

Salaries or benefits listed for an individual clinician exceed the expected threshold.

Contract cost is unusually high

Contract costs listed for an individual clinician exceed the expected threshold.

Benefit to salary ratio is unusually high

Benefits for an individual clinician are more than an established percentage of salary cost.

Below is an example of a completed **Professional Type Cost** section of the cost reporting spreadsheet:

Basic Information		Cost		Hours		Direct Time Allocation	
Cost Information							
Last Name	First Name	Salary	Benefits	Contract	Total Cost	Regional Revenue Offset	Net Cost
John	Lennon	\$ 50,000.00	\$ 20,000.00		\$ 70,000.00		\$ 70,000.00
Paul	McCartney	\$ 40,000.00	\$ 10,000.00		\$ 50,000.00	\$ 5,000.00	\$ 45,000.00

3. **Professional Type Hours July 1 through December 31:** CCS providers must collect hours spent on CCS direct services, which includes CCS direct service time, documentation time, and travel time as outlined in the ForwardHealth Provider Update. This step also requires reporting direct time that the professional may have spent on programs other than CCS (e.g., WIMCR programs). Providers will also be required to separate direct hours based on federal fiscal year to ensure the appropriate FFP is applied during reconciliation. This step helps to ensure that services are only reported for a single program. The professional type, first name, and last name of each clinician will be prepopulated based on information entered under the Professional Type Basic Information section. The following fields are collected:

- **CCS Total Direct Hours July 1 through December 31.** Enter total hours providing direct CCS services for dates of service July 1, 2014 through December 31, which includes any clinician travel time associated with the direct CCS service. Consistent with WIMCR cost reporting, direct services are those that would be billable to Medicaid if all recipients were Medicaid eligible.

Direct hours reported in this section will be reconciled based on the FFP for the applicable Federal Fiscal Year (FFY). While regional providers will receive the state and federal share of Medicaid-allowable costs, this step allows the state to reconcile the appropriate percentage of state and federal share reimbursed to providers. This step also ensures non-regional providers receive the appropriate federal reimbursement on interim claims. Hours should reflect only cost incurred from July, 1 2014 – December 31, 2014.

- **CCS Direct Support Hours.** Enter all time spent on the CCS program aside from CCS direct hours. Examples in the CCS ForwardHealth Provider Update include:
 - o Staff training directly related to CCS,
 - o A CCS supervisor's time supervising CCS staff providing direct hours,
 - o CCS administrator's time spent on general CCS administration,
 - o Time spent by staff not described in DHS 36.10(2)(g), Wis. Adm. Code, directly supporting the CCS program,
 - o Non-staff costs that directly contribute to the CCS program (e.g. CCS training materials and CCS supplies),
 - o All other direct CCS program support costs.

- **Paid Time Off (PTO).** Enter total sick time, vacation time, and personal time used by the employee during the reporting period. This category is consistent with the WIMCR cost reporting definition for PTO.
- **Other Non-CCS Hours.** Enter all other paid hours for any program or activity outside of CCS. This definition is consistent with the non-WIMCR hours definition in WIMCR.
- **Total Paid Hours (prepopulated).**
This field represents the sum of the hours reported in the Direct Hours, Direct Support Hours, PTO, and Other Non-CCS hours fields.
- **Paid Hours Net of PTO (prepopulated).** This field represents Total Paid Hours less the PTO field.
- **Region Direct.** Enter all CCS Direct Hours spent providing services on behalf of another county reporting entity for which the reporting entity received payment. Corresponding payment should be reflected under “Regional Revenue Offset”.
- **Region Support.** Enter all CCS Direct Support Hours providing services on behalf of another county reporting entity for which the reporting entity received payment. Corresponding payment should be reflected under “Regional Revenue Offset”.
- **Net Agency Paid (prepopulated).** This field represents Total Paid Hours net of PTO less the Region Direct and Region Support fields.

Professional Type Hours - Desk Audit Reviews:

Hours reported for all personnel are unusually low
The total paid hours reported for all [professional type] staff are unusually low.

CCS Direct hours are unusually high
The ratio of CCS Direct Hours to Total Paid Hours exceeds the established threshold.

Total paid hours unusually high
The total paid hours reported for an individual clinician are unusually high.

Cost per paid hour is unusually high/low
Total cost divided by total paid hours for an individual clinician is unusually high/low.

Below is an example of a completed **Professional Type Hours** section of the cost reporting spreadsheet:

Basic Information		Cost		Hours		Direct Time Allocation				
Hours										
Last Name	First Name	CCS Direct Service	CCS Direct Support	PTO	Other Non CCS	Total Paid Hours	Net of PTO	Region Direct	Region Support	Net Agency Paid
John	Lennon	1,000.00	200.00	80.00	500.00	1,780.00	1,700.00			1,700.00
Paul	McCartney	400.00	500.00	100.00	1,000.00	2,000.00	1,900.00	200.00	100.00	1,600.00

Direct Service Intergovernmental Agreements Example

The example below demonstrates how a regional shared clinician should be reflected on the cost report of the county or tribe employing the shared clinician (County A) as well as the county or tribe contracting out for the shared clinician's services (County B).

Intergovernmental Agreement Example - Direct Service						
Overview	County A Basic Information	County A Cost	County A Hours	County B Basic Information	County B Cost	County B Hours
CCS Direct Service Clinician: Clinician 1 is a full time employee of County A (40 hrs per week, 2080 hours per year), receiving a salary of \$50,000 and benefits of \$20,000. Clinician 1 spends 10% of their time providing CCS direct services on behalf of County B. County B pays County A \$15,000 for Clinician 1's time.	County A reports Clinician 1 as an "Agency Employee - Regional Shared", and reports an NPI	County A reports salary of \$50,000, benefits of \$20,000 and a Regional Revenue Offset of \$15,000.	County A reports total paid hours of 2080, and "Region Direct" hours of 208	County B reports Clinician 1 as a "Contractor - Regional Shared" and reports an NPI	County B reports \$15,000 contract cost	County B reports 208 CCS Direct Service Hours

Report List Item: Direct Service Non-Personnel Costs

Enter the non-personnel costs associated with the Direct Service clinicians included in the Professional Type sections above. This information is not broken down by individual clinicians. Consistent with WIMCR cost reporting, the allowable cost categories for direct service non-personnel costs include:

Clinician Travel Expenses: expenses incurred by clinicians listed in the Professional Type sections to travel to and from a location for the provision of a direct service (CCS or non-CCS). This may include mileage expenses, tolls, meals, lodging, and other similar expenses.

Note that clinician travel expenses do not include clinician travel time costs submitted on interim claims. Clinician travel time is accounted for in Direct Costs.

Clinician Training: expenses incurred by the agency or region related to the training of direct service clinicians included in the Professional Type sections. This may include expenses for conference attendance, or continuing education needed to maintain licensure.

Direct Medical Service Materials: expenses incurred by the agency or region for the purchase of materials and supplies that are used in the provision of a direct service (CCS or Non-CCS).

The **total cost** associated with each of the direct service non-personnel expense categories is collected and allocated to the CCS program.

Direct Service Non-Personnel - Desk Audit Reviews:

Non-personnel cost to salary & benefit or contract cost ratio is unusually high

The ratio of direct service non-personnel cost to personnel cost is unusually high.

Each reporting entity will have the option of using the allocated CCS cost based on the distribution of the CCS direct service program hours and Other Non CCS hours as reported in the Direct Service by Professional Type sections, or manually entering CCS cost. The option to override the automated allocation for direct service non-personnel must be consistent with 2014 WIMCR reporting.

Expenses reported in the direct service non-personnel section of the cost report should be inclusive of the expenses incurred for only those staff that were included in the Direct Service Data by Professional Type sections. In other words, if a clinician is not a provider of a direct CCS service, the cost of travel, training and Direct Medical Service Materials associated with that clinician should not be included.

- **Total Cost.** Enter the total cost for all clinicians listed under the Professional Type cost reporting section for the three Direct Service Non-Personnel Cost categories: Clinician Travel Expenses, Clinician Training, Direct Medical Service Materials.
- **CCS Cost.** Decide whether to report the automatically allocated CCS cost amount or manually enter the CCS cost share for the three Direct Service Non-Personnel cost categories. CCS cost cannot exceed total cost. The option to override the automated allocation for direct service non-personnel must be consistent with 2014 WIMCR reporting.
- **Other Non CCS Cost (prepopulated).** Other Non CCS Cost field reflects the difference between total cost and CCS cost.

Below is an example of a completed **Direct Service Non-Personnel Cost** section of the cost reporting spreadsheet:

Cost Category	Total Cost	CCS Cost	Other Non CCS Cost
Clinician Travel	\$ 5,000.00	\$ 2,000.00	\$ 3,000.00
Clinician Training	\$ 2,000.00	\$ 1,000.00	\$ 1,000.00
Direct Medical Services Materials and Supplies	\$ -	\$ -	\$ -
	7,000.00	3,000.00	4,000.00

Report List Item: Group Services

CCS providers must capture the total number of group service hours provided by each CCS professional type. The following information will be provided or entered in this section:

Total CCS Direct Hours (prepopulated). The field will provide the total CCS direct hours for each professional type based on information reported in previous fields. This field includes direct hours for both group and individual CCS services.

CCS Group Services Hours. Enter the total number of hours corresponding to each CCS professional type that provided a CCS service to a group of clients. CCS providers should exclude service hours for individual clients in this field.

Note: This field should only include group services participants that are Medicaid-eligible and are CCS members. Non-Medicaid or Non-CCS group participants should not be included.

CCS Individual Services Hours (prepopulated). This field represents the difference in total CCS direct hours and total CCS group services hours.

Below is an example of a completed **Group Service Hours** section of the cost reporting spreadsheet:

Group Service Hours and Costs - Desk Audit Reviews:

Group service hours exceed CCS direct hours
Group service hours exceed CCS direct hours for a specific professional type.

Paid claims exceed CCS group services hours reported

Medicaid paid claims (converted to hours) exceed CCS direct hours for a specific professional type staff providing CCS group services.

Average participants per unit less than two
By definition, group services require a minimum

Personnel FTE			
Professional Type	CCS Hours	Group Hours	CCS Individual Hours
Advanced Practice Nurse Practitioner	0.00		0.00
Bachelors Degree Level	1,000.00	500.00	500.00
Masters Degree Level	0.00		0.00
Psychiatrist/MD	200.00	100.00	100.00
Less than Bachelors Degree Level	0.00		0.00
PhD Psychologist/Doctoral Level	0.00		0.00
Registered Nurse/Licensed Practical Nurse	0.00		0.00
Qualified Treatment Trainees	0.00		0.00
Total	1,200.00	600.00	600.00

Billable Units/Units on Interim CCS Claims (prepopulated). This field will display the 15 minute increment allowable under CCS for Dates of Service after July 1, 2014.

CCS Group Services Units (prepopulated). This field converts the total CCS group hours reported to the total number of units of service provided based on 15 minute billable units.

Total Duplicated Participant Count (CCS and Non-CCS). Enter the total duplicated participant count for all group services during the cost reporting period. The total count should include both CCS and non-CCS members that attended group services. Example: if there are two group sessions, the first with 11 participants and the second with 15 participants, the total participants would be 26 participants. If 4 participants attended both group sessions, the total duplicated count would still be 26 participants.

CCS Duplicated Participant Count. Report the total duplicated number of CCS participants attending all group services units. Example: if there are two group sessions, the first with 11 participants and the second with 15 participants, the total participants would be 26 participants. If 4 participants attended both group sessions, the total duplicated count would still be 26 participants.

Note: CCS Duplicated Participant Count should not exceed Total Duplicated Participant Count (CCS and Non-CCS)

Average CCS Participants per Unit (prepopulated). This field will be calculated by taking the CCS duplicated participant count and dividing by the total CCS group services units.

Below is an example of a completed **Group Service Participants** section of the cost reporting spreadsheet:

Hours			Participants			
Personnel Cost						
Category	Group Hours	Units	Total Group 15 Minute Increments	Total Duplicated Participant Count	CCS Duplicated Participant Count	Average CCS Participants Per Unit
Advanced Practice Nurse Practitioner	0.00	15 Minute	0.00			
Bachelors Degree Level	500.00	15 Minute	2,000.00	7,000.00	5,000.00	2.50
Masters Degree Level	0.00	15 Minute	0.00			
Psychiatrist/MD	100.00	15 Minute	400.00	30,000.00	20,000.00	50.00
Less than Bachelors Degree Level	0.00	15 Minute	0.00			
PhD						
Psychologist/Doctoral Registered	0.00	15 Minute	0.00			
Nurse/Licensed Practical	0.00	15 Minute	0.00			
Qualified Treatment Trainees	0.00	15 Minute	0.00			
Total	600.00		2,400.00	37000.00	25000.00	

Report List Item: General Overhead Costs

General overhead costs function as an “add on” to direct costs per unit on a cost report. A county may only report general overhead costs if the county also reports direct costs. General overhead costs reflect central services related to overall agency operations that are allocable to all agency programs, including CCS.

CCS programs must report general overhead costs, which reflect central services related to overall agency operations that are allocable to all agency programs including CCS. General overhead costs consist of general overhead personnel costs and general overhead non-personnel costs.

1. Category and FTE. Report all general overhead personnel and Non Personnel cost categories and FTE information

- **Category.** Category of overhead includes Personnel and Non Personnel categories including accounting, administrative assistant, billing, clerical, emergency services, financial, human resources, legal, plant maintenance, program director, lease and rental, office supplies, professional liability insurance, utilities, and “other – please describe.” These categories are consistent with WIMCR cost reporting.
- **Regional Shared.** Indicate “Yes” if providers in this category of service performed overhead services on behalf of other reporting entities in the region.
- **Total FTE Count (If Personnel).** Report the total FTEs applicable to each overhead service. One FTE is equal to 40 hours per week and 2,080 hours per year.
- **Regional FTE (if Regional Shared).** Enter shared Overhead FTE count providing services on behalf of another county reporting entity for which the reporting entity received payment. Corresponding payment should be reflected under “Regional Revenue Offset”.
- **Net FTE (Prepopulated).** Difference between Total FTE and Regional Shared FTE.
- **Other Description.** Please describe any general overhead personnel cost listed under the “Other – Please Describe” category.

Below is an example of a completed **Overhead Category and FTE** section of the cost reporting spreadsheet:

Category and FTE					
Cost					
Cost Allocation					
Personnel FTE					
Category	Regional Shared	Total FTE	Regional FTE	Net FTE	Other Description
Personnel - Administrative Assistant	Yes	5.00	3.00	2.00	
Non Personnel - Office Supplies	No				
Non Personnel - Other - Please Describe	Yes				Building Rent
Personnel - Billing	No			0.00	

2. Overhead Cost. Report all general overhead Personnel and Non Personnel costs for various agency cost categories.

- **Salary (Personnel only).** Report the total gross salary amount paid to FTEs in each overhead service. Consistent with WIMCR cost reporting, the amount reported in this field should be inclusive of all cost from which payroll taxes are deducted, including regular wages or extra pay, paid time off (e.g., sick or annual leave), overtime, bonuses or longevity, stipends, and cash bonuses and/or cash incentives. Reimbursements for expenses such as mileage or other travel reimbursements should not be included in this field.
- **Benefits (Personnel only).** Report the total benefits paid to FTEs in each overhead service. Consistent with WIMCR cost reporting policies, the benefits field should include employer-paid health/medical, life, disability, or dental insurance premiums, as well as employer-paid child day care for children of employees paid as employee benefits on behalf of your staff, retirement contributions, and worker's compensation costs. Report the expended amounts paid by the county agency which are directly associated with each staff member by type of employee benefit. Employee benefits include: employee insurance, social security contributions, state retirement system contributions, tuition reimbursement, unemployment insurance, workers' compensation, other employer paid health benefits, other employer paid employee benefits.
- **Contract Costs (Personnel only).** Report any costs incurred for the purchase of general overhead personnel staff. Consistent with WIMCR cost reporting, the reported contract costs should be the total costs for the agency or individual as paid by the county agency for the reporting period.
- **Total Costs (prepopulated if Personnel).** For county and tribe staff members, this field will represent the sum of salary and benefits. For contractors, this field will represent the reported contract cost. For Non Personnel categories, this will be an open field in which total cost should be reported.

General Overhead - Desk Audit Reviews:

Total CCS-specific salary and benefit costs (direct service, direct support, and general overhead) exceed agency wide personnel expenditures

Agency wide personnel expenditures is meant to capture all personnel cost; consequently, cumulative personnel expenditures should not exceed agency wide personnel.

Total cost per FTE unusually high/low

Total cost per FTE falls outside of the expected range

Ratio of total overhead cost (personnel and non-personnel) allocated to CCS divided by all CCS costs exceed expected threshold

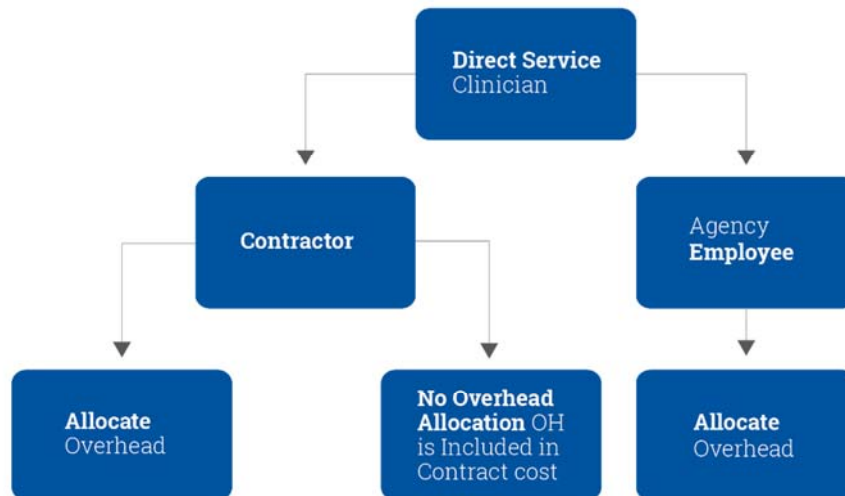
Overhead amounting to greater than 40 percent of total direct service (personnel and non-personnel) and direct support cost.

Below is an example of a completed **Overhead Cost** section of the cost reporting spreadsheet:

Category and FTE		Cost		Cost Allocation		
Personnel Cost						
Category	Salary	Benefits	Contract Cost	Total Cost	Revenue Offset	Net Cost
Personnel - Administrative	\$ 6,000.00	\$ 4,000.00		\$ 10,000.00	\$ 1,000.00	\$ 9,000.00
Non Personnel - Office Supplies				\$ 60,000.00		\$ 60,000.00
Non Personnel - Other - Please Describe				\$ 30,000.00	\$ 450.00	\$ 29,550.00
Personnel - Billing			\$ 80,000.00	\$ 80,000.00		\$ 80,000.00

3. **Allocating General Overhead to CCS Program.** General Overhead costs will automatically be allocated to CCS and non-CCS programs based on FTE counts provided in previous sections of the cost reporting spreadsheet. An overhead amount per FTE will be calculated for the agency, then the number of CCS FTEs will be used to allocate overhead to the CCS program.

When entering a clinician, the CCS program will identify contractors and agency employees. The CCS program will be required to identify whether or not overhead should be applied to contractors. Overhead cost will be automatically allocated to agency employees.



For example, if a region reported total Overhead Personnel & Non-Personnel costs of \$200,000 and had 50 total agency wide FTEs (net of overhead FTEs), the average overhead per FTE would equal \$4,000. The average overhead per FTE would then be multiplied by the total number of CCS FTEs. If a CCS program had 5 FTEs, the total CCS Overhead would equal \$20,000 (5 FTEs X \$4,000 per FTE).

As new programs are developed and new regional structures are created, it is expected that Direct Service and Direct Support time allocated to CCS will increase. The increase in CCS direct service and support needed to launch a new CCS program or alter an existing provider structure will result in a higher percentage of total overhead dollars allocated to CCS. The anticipated spike in both direct and overhead cost allocated to CCS is consistent with federally allowable cost settlement guidelines.

Note that the CCS allocation methodology will continue to be consistent with WIMCR cost reporting (as implemented in fall 2014 for CY 2013 WIMCR costs). While the WIMCR cost reporting process will use a new web tool, CCS will continue to use a spreadsheet format.

CCS providers hoping to override automated overhead allocations can submit a formal written override request during the reporting period. CCS overhead override requests will be reviewed by DHS along with WIMCR overhead override requests to ensure agency-wide reporting consistency. Providers that elect to manually allocate overhead on their 2014 CCS reports will also be required to manually allocate overhead on their 2014 WIMCR reports.

The following prepopulated sections on the cost reporting spreadsheet will allow the CCS program to view the general overhead costs allocated to CCS:

- **Total General Overhead (prepopulated).** This field displays general overhead personnel costs and general overhead non-personnel costs by category.
- **General Overhead Allocated to CCS (prepopulated).** This field multiplies the average overhead per FTE by the CCS FTEs to which agency/region allocates overhead to calculate the total overhead costs that should be allocated to the CCS program.
- **Other – Non CCS (prepopulated).** Difference between total cost for a given category of overhead and cost allocated to CCS.

Below is an example of a completed **Allocating General Overhead to CCS Program** section of the cost reporting spreadsheet:

Cost Information			
Category	Total Overhead Cost	Overhead Allocated to CCS	Other - Non CCS
Personnel - Administrative Assistant	\$ 9,000.00	\$ 1,298.08	\$ 7,701.92
Non Personnel - Office Supplies	\$ 60,000.00	\$ 8,653.85	\$ 51,346.15
Non Personnel - Other - Please Describe	\$ 29,550.00	\$ 4,262.02	\$ 25,287.98
Personnel - Billing	\$ 80,000.00	\$ 11,538.46	\$ 68,461.54

Overhead Intergovernmental Agreement Example

The example below demonstrates how a regional shared overhead provider should be reflected on the cost report of the county or tribe employing the shared employee (County A) as well as the county or tribe contracting out for the shared employee's services (County B).

Intergovernmental Agreement Example - Overhead				
Overview	County A Category and FTE	County A Cost	County B Category and FTE	County B Cost
Overhead Provider: Administrative Assistant 1 is a full time employee of County A (40 hrs per week, 2080 hours per year), receiving a salary of \$75,000 and benefits of \$25,000. Administrative Assistant 1 spends 20% of their time providing general administrative services on behalf of County B. County B pays County A \$25,000 for Administrative Assistant 1's time.	County A reports Clinician 1 as an Administrative Assistant and selects "Yes" for Regional Shared. County A reports Total FTE of 1, and Regional Shared FTE of .8	County A reports Salary of \$75,000, benefits of \$25,000 and revenue offset of \$25,000	County B reports Clinician 1 as an Administrative Assistant and selects "Yes" for Regional Shared. County B reports Total FTE of .2	County B reports Contract Cost of \$25,000

Report List Item: Federal Funds and Reductions

CCS providers are required to report the receipt of federal grant funding which is used to offset the cost of a CCS program. The following are data fields on the Federal Funds screen of the CCS Cost Report:

- **Total Allocated Cost.** Total Allocated Cost includes previously reported direct service cost, direct support cost and overhead cost which has been allocated to CCS.
- **Federal Funds and Reductions.** Please use this space to identify any federal grant dollars applied to offset the cost of your agency's CCS program. Federal dollars include, but are not limited to:
 - Substance Abuse Block Grant
 - Mental Health Block Grant
 - Social Services Block Grant
- **Net Cost.** Total Allocated Cost - Federal Funds and Reductions

Below is an example of a completed **Federal Funds and Reductions** section of the cost reporting spreadsheet:

Program	Total Cost	Federal Funds and Reductions	Net Cost
Comprehensive Community Services	\$ 95,039.17	\$ 4,000.00	\$ 91,039.17
Total	\$ 95,039.17	\$ 4,000.00	\$ 91,039.17

VI - Next Steps

Consolidated CCS Summary

Once all data has been entered into the 2014 CCS cost report, cost and hours data for the Legacy CCS Report (DOS 1/1/2014 – 6/30/2014) as well as the Updated CCS Report (DOS 7/1/2014 – 12/31/2014) will be automatically summarized into a Consolidated CCS Summary.

No data entry is required for the Consolidated CCS Summary; however, it is recommended that each provider review consolidated 2014 CCS cost information reflected on the Consolidated CCS Summary tab prior to submitting their 2014 CCS report.

Cost Report Submission

Completed 2014 CCS Reports can be submitted via email to PCG at wiccs@pcgus.com on or before the deadline for 2014 cost report completion.

Management Reports

Additional information relating to CCS cost settlement calculations and management reports which will be made available to providers will be forthcoming.