

DETAILING UNIT COSTS

Use to determine the **unit** cost for providing the following levels of services:

TABLE 1

Level of Service	Unit Definition
Detox	24 hours
Residential III.5	24 hours
Residential III.1 Women's Services	24 hours
Intensive Outpatient	3 hours-Adult, 2 hours-Adolescent
Outpatient-1x1	50 minutes
Outpatient- Group	50 minutes
Outpatient COD-1x1	50 minutes
Outpatient COD-Group	50 minutes
OMT\OP\AMB Detox	Weekly

Please include all costs associated with providing the services, direct and indirect (e.g., personnel, training, facility, etc.). Indicate what you have included within your calculations by a percentage in the items below. Use N/A if the cost does not apply to the cost you provide in Table 2. Please do not leave a blank line.

- Personnel Related Expenses
 - _____ % Counselor
 - _____ % Administration (Program Director, Data, Fiscal, etc.)
 - _____ % Residential Client Advocates/Case Managers/Nutrition
 - _____ % Health Insurance/Personnel
 - _____ % Training and Travel
 - _____ % Non-Employee Compensation
 - _____ % Clinical Supervisor

- Operating
 - _____ % Facility Costs (Rent/Lease, Utilities, Maintenance, etc.)
 - _____ % Depreciation
 - _____ % Supplies/Food/Household
 - _____ % Finance Charges/Interest Expense
 - _____ % Licenses, Permits, Dues
 - _____ % Client Transportation

- Other Items by %
 - _____ % Reserve for Bad Debts
 - _____ % Medical/Psychiatric Services/Medications
 - _____ % Miscellaneous, A-133 Audit Expenses, Recreation, Marketing/Advertising, Postage and Shipping

In the table below, indicate the cost per unit and what percent of the cost is administrative. Factor in all expenses used to support these services, not just what is supported from the Substance Abuse Prevention and Treatment Agency (SAPTA).

TABLE 2

Level of Service	Cost Per Unit	Admin. %
Detox	\$	%
Residential III.5	\$	%
Residential III.1 Women's Serv	\$	%
Level of Service	Cost Per Unit	Admin. %
Intensive Outpatient	\$ -Adult	%
	\$ -Adolescent	%
Outpatient-1x1	\$	%
Outpatient-Group	\$	%
Outpatient COD-1x1	\$	%
Outpatient COD-Group	\$	%
OMT\OP\AMB Detox	\$	%

In the space below, please provide information on how you determined the costs:

Program Name: