Document	Page or Tab
Cost Report Template	Provider Information
Cost Report Template	CC PPS-2 Rate
Cost Report Template Instructions	CC PPS-2 Rate, Monthly Visits Throughout
Cost Report Template	Daily Visits
Cost Report Template	Monthly Visits
Instructions	Title Page
Instructions	3
Instructions	5

Instructions	5
Instructions	5
Instructions	6
Instructions	7
Instructions	8

Instructions	10 to 11
Instructions	15
Instructions	22

Instructions	24
Instructions	27

Cost Report	All Tabs
Insturctions	Entire Document
Instructions	5
Instructions	6
Instructions	6
Instructions	CC PPS-1 Rate Tab

Instructions	CC PPS-2 Rate Tab

Instructions	CC PPS-2 Rate Tab
Instructions	CC PPS-2 Rate Tab
Instructions	Daily Visit Tab
Instructions	Daily Visit Tab

Instructions	Monthly Visit Tab
Instructions	Monthly Visit Tab
Instructions	Services Provided Tab
Instructions	2
Instructions	6
Instructions	24

Original
Included line number 10 for supervisor identification and hours worked
Included Part 1a (lines 1-18), Part 1b (lines 19-21), Part 1c (lines 22-29) and Part 2 (lines 30-34) to identify costs for staffing consistent with the trial balance tab
e.g., Standard Population Costs for CCBHC Services: At or Below 1a
Did not include line items for additional anticipated visits
Did not include line items for additional anticipated visits
28-Aug-15
Included "The time required to complete this information collection is estimated to average XX minutes per response, including the time to review instructions, search existing data resources, gather the needed data, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850."
Line 9: Enter the names and the NPI of all (1) behavioral health professionals who provide services directly at the CCBHC and (2) providers who have Designated Collaborating Organization (DCO) relationships with the CCBHC. Enter the names in column 1 and the corresponding NPI in column 2. Use lines 9a–9o for this information. If additional behavioral health professionals are needed, in 9o, enter “see additional information in the comments tab” and continue listing the names and NPIs in the comments tab until all behavioral health professionals are identified.

Line 10: List the names of all supervisory behavioral health professionals in column 1 and the hours of supervision that they provide in column 2. Use lines 10a–10o for this information. If additional supervisory behavioral health professionals are needed, in 10o, enter “see additional information in the comments tab” and continue listing the names and hours of supervision in the comments tab until all supervisory behavioral health professionals are identified.
Line 14: Enter the hours of operation and the total hours for each day of the week that the site operates as a CCBHC.
Line 15: If the answer to Line 12 is Yes (the site operates as other than a CCBHC), enter the hours of operation and total hours for each day of the week that the site operates as other than a CCBHC. If the answer to line 12 is No, skip this question.
Line 13: Enter the hours of operation and the total hours for each day of the week that the site operates as a CCBHC. Line 14: If the answer to 11 is Yes (the site operates as other than a CCBHC), enter the hours of operation and the total hours for each day of the week that the site operates as other than a CCBHC. If the answer to 11 is No, skip this line.
Use the CC PPS-1 Rate tab to determine the all-inclusive CCBHC payment rate per daily visit for the reporting period.

Use the CC PPS-2 Rate tab to summarize the costs of health care staff and service providers under agreements as Designated Collaborating Organizations (DCOs) and to allocate indirect costs to CCBHC services. The costs must be allocated to the categories identified in section 12 (Monthly Visits tab) of this document.

PART 1A – CCBHC STAFF COSTS
Lines 1–16 of Part I in this tab list the types of practitioners (positions) who provide CCBHC services.
Lines 1–16: Enter the allocated costs for CCBHC services under each population group in columns 1a–10b, as described above. The total column at the far right of this table sums the "Total Population Costs" for each type of practitioner.
Line 17: Enter a subtotal of costs for all other appropriate staff not listed on lines 1–16, and specify in the Comments tab.
Line 18: "Subtotal staff costs," which is calculated by adding the amounts on lines 1–17, is automatically populated in each cell on this line.
PART 1B: CCBHC COSTS UNDER AGREEMENT
Line 19: Enter the cost of visits for CCBHC services under DCO agreement by population category in columns 1a–10b.
Line 20: Enter a subtotal of all other CCBHC costs, and specify in the Comments tab.
Line 21: "Subtotal costs under agreement," which is calculated by adding lines 19 and 20, is automatically populated in each cell on this line.
PART 1C: OTHER DIRECT CCBHC COSTS
Lines 22–26: Enter the net costs from the Trial Balance tab, lines 22–26, column 9 (Net Expenses), into each population category, as appropriate. Document the allocation methods in the Allocation Descriptions tab. Acceptable allocation methods include allocating by encounter, by visit, or by unique visit month. If direct expenses can be applied to a specific column, apply those direct expenses prior to allocating any remaining amounts that are not specifically attributable to a certain column.
Line 27: Enter a subtotal of all net costs for other categories not listed on lines 22–26, and specify in the Comments tab.
Line 28: "Subtotal other direct CCBHC costs," which is calculated by adding lines 22–27 above, is automatically populated in each cell on this line.
Line 29: "Total cost of CCBHC services," which is calculated by adding lines 18, 21, and 28 above, is automatically populated in each cell on this line.
A validation check appears below Part I to verify that the amount in the Total Population Costs column on line 29 (on the far right) is equal to the subtotal amounts in the Trial Balance tab, line 29, column 9.
PART 2 – ALLOCATION OF INDIRECT COSTS
Line 30: "Total direct costs of CCBHC services" is automatically populated

Line 50: Enter the subtotal of direct costs for non-CCBHC services covered by Medicaid, excluding overhead, such as physician visits for physical care, and specify in the Comments tab.

Tabs for the Cost Report (in the following order): Provider Information, CC PPS-1 Rate, CC PPS-2 Rate, Trial Balances, Trial Balance Reclassifications, Trial Balance Adjustments, Allocation Descriptions, Indirect Cost Allocation, Anticipated Costs, Daily Visits, Monthly Visits, Services Provided, Comments, Certification

Line 11: Enter “Yes” if the site operates as other than a CCBHC. Otherwise, enter “No.” If No is entered, skip lines 14 and 16.

Line 14: If the answer to Line 11 is Yes (the site operates as other than a CCBHC), enter the hours of operation and total hours for each day of the week that the site operates as other than a CCBHC. Note, the hours provided in line 13 and 14 may overlap if the site operates as a CCBHC and other than a CCBHC over the same time period. If the answer to line 12 is No, skip this question.

Line 15: Enter a description of any excluded satellite facilities and the reason for the exclusion.

"Use the CC PPS-1 Rate tab to determine the all-inclusice CCBHC payment rate per daily visit for the reporting period. Use the CC PPS-1 Rate tab to calculate a preliminary PPS rate per daily visit based on demonstration costs for all CCBHC demonstration services provided to all CCBHC clinic users irrespective of payer."

"Use the CC PPS-2 Rate tab to calculate a preliminary PPS rate based on costs for all CCBHC demonstration services provided to all CCBHC clinic users irrespective of payer. The calculation of the PPS rate is preliminary and will be finalized by the state in accordance with the state's policy concerning outlier payments. Costs must be allocated to the standard and special populations identified in Section 10 (Monthly Visits tab) of this document. One acceptable method of allocating cost by population is multiplying a cost-to-charge ratio by charges incurred for each population. The cost-to-charge ratio represents total costs, including anticipated costs for all users regardless of payer divided by all charges for all users regardless of payer. Each individual charge is multiplied by the ratio to estimate the cost of performing each service. Those costs should be categorized by patient and evaluated to determine if costs exceed the outlier threshold.

The use of the cost-to-charge ratio requires a uniform charge master for each of the demonstration services. The state may require an attestation that the CCBHC is using a uniform charge master for each individual service provided, not just the first time the service is provided during the month. As a condition of participation in the demonstration program, CCBHCs must collect and report encounter, clinical outcomes, and quality improvement data. CCBHC consumer claim or encounter data must be linkable to the consumer's pharmacy claims or utilization information, inpatient and outpatient claims, and any other claims or encounter data necessary to report the measures. The CCBHC should be recording this information per CCBHC criteria 5.a.4.

Part 1 Column Descriptions- ie: total charges

Line 9: "Total allowable CCBHC costs" is automatically populated on this line from the allowable CCBHC costs on line 4 above."

Line 3: "Enter the total number of additional anticipated unique patient visit days for patients irrespective of payer receiving CCBHC demonstration services not included above. The additional visits should be for the anticipated increase in unique patients coresponding to the additional service costs identified in the anticipated costs tab. Anticipated visits are allowed for demonstration year 1 only. Demonstration year 2 requires actual data."

Line 5: "Total daily visits for patients receiving CCBHC services," which is calculated by adding the amounts on lines 1 thru 3 above, is automatically populated on this line."

Line 3: "Enter the total number of additional anticipated unique patient visit months for patients irrespective of payer receiving CCBHC demonstration services not included above. The additional visits should be for the anticipated increase in unique patients coresponding to the additional service costs identified in the anticipated costs tab. Anticipated visits are allowed for demonstration year 1 only. Demonstration year 2 requires actual data."

Line 5: “Total months patients received CCBHC services,” which is calculated by adding the amounts on lines 1 thru 3 above, is automatically populated on this line."

"This number represents the total quantity (units) of services provided, as opposed to the number of days that each patient received services as described in section 11 or the number of months that each patient received services as described in Section 12."

Table 2, column 1: **"Monthly** or **Daily** Visits"; Column 2: "Read Section**s** 9 **and** 10…", and "Read Sections 13 **and** 14…"

Each clinic filing under consolidated cost reporting must complete this section of the worksheet. Complete Part 2 for each site included in the consolidation.

Complete Part 2 for each satellite site. Add all additional lines via the Trial Balance tab prior to copying Part 2 for each site. The entire Part 2 for each site may be copied and pasted below the original PART 2 – SERVICES PROVIDED BY SITE.

Updated
Removed supervisor hours and renumbered Part 1 accordingly
Removed staff level detail and consolidated indirect cost allocations with direct cost allocations to, instead, implement a cost-to-charge ratio approach for apportionment of costs between population groups
e.g., Standard Population Costs for CCBHC Services: At or Below the Outlier Threshold 1a
Added a line for additional anticipated visits
Added a line for additional anticipated visits
28-Oct-15
Removed the statement as the comment period was provided from August through October
Line 9: Enter the names and the NPI of all (1) behavioral health professionals who provide services directly at the CCBHC and (2) providers who have Designated Collaborating Organization (DCO) relationships with the CCBHC. Enter the names in column 1 and the corresponding NPI in column 2. Use lines 9a–9o for this information. If additional behavioral health professionals are needed, in 9o, enter “see additional information in the comments tab” and continue listing the names and NPIs in the comments tab until all behavioral health professionals are identified. A clinic must report all provider NPIs to the extent available. If no NPI is available, leave column 2 blank.

Removed entire section and renumbered Part 1 subsequently
Line 13: Enter the hours of operation and the total hours for each day of the week that the site operates as a CCBHC. Clinic hours, outside of the 24 hour mobile crisis team, should be reported to help evaluate access to care.
Line 14: If the answer to Line 11 is Yes (the site operates as other than a CCBHC), enter the hours of operation and total hours for each day of the week that the site operates as other than a CCBHC. Note, the hours provided in line 13 and 14 may overlap if the site operates as a CCBHC and other than a CCBHC over the same time period. If the answer to line 12 is No, skip this question.
Line 13: Enter the hours of operation and the total hours for each day of the week that the site operates as a CCBHC. Clinic hours, outside of the 24 hour mobile crisis team, should be reported to help evaluate access to care. Line 14: If the answer to 11 is Yes (the site operates as other than a CCBHC), enter the hours of operation and the total hours for each day of the week that the site operates as other than a CCBHC. Note, the hours provided in line 13 and 14 may overlap if the site operates as a CCBHC and other than a CCBHC over the same time period. If the answer to 11 is No, skip this line.
Use the CC PPS-1 Rate tab to calculate a preliminary PPS rate per daily visit based on costs for all CCBHC demonstration services provided to all CCBHC clinic users irrespective of payer.

Use the CC PPS-2 Rate tab to calculate a preliminary PPS rate based on costs for all CCBHC demonstration services provided to all CCBHC clinic users irrespective of payer. The calculation of the PPS rate is preliminary and will be finalized by the state in accordance with the state's policy concerning outlier payments.
The costs must be allocated to the standard and special populations identified in section 12 (Monthly Visits tab) of this document. One acceptable method of allocating cost by population is multiplying a cost-to-charge ratio by charges incurred for each population. The cost-to-charge ratio represents total costs, including anticipated costs for all users regardless of payer divided by all charges for all users regardless of payer. Each individual charge is multiplied by the ratio to estimate the cost of performing each service. Those costs should be categorized by patient and evaluated to determine if costs exceed the outlier threshold.
The use of the cost-to-charge ratio requires a uniform charge master for each of the demonstration services. The state may require an attestation that the CCBHC is using a uniform charge master for each individual service provided, not just the first time the service is provided during the month. As a condition of participation in the demonstration program, CCBHCs must collect and report encounter, clinical outcomes, and quality improvement data. CCBHC consumer claim or encounter data must be linkable to the consumer's pharmacy claims or utilization information, inpatient and outpatient claims, and any other claims or encounter data necessary to report the measures. The CCBHC should be recording this information per CCBHC criteria 5.a.4.

Line 1: Enter the covered charges for CCBHC services under each population group in columns 1a–10b, as described above. The total column at the far right of this table sums the "Total Population Charges."
Line 2: For demonstration year 1 (DY1) only, enter the anticipated covered charges for CCBHC services under each population group in columns 1a–10b, as described above. The total column at the far right of this table sums the "Total Population Charges."
Line 3: Line 3 automatically populates with the sum of line 1 and line 2.
Line 4: Line 4 automatically populates the total column with the total direct costs for CCBHC services from the Trial Balance tab, column 9, line 29.
Line 5: Line 5 automatically populates the total column with the total indirect costs for CCBHC services from the Indirect Cost Allocation tab, line 16.
Line 6: Line 6 automatically populates the total column with the sum from line 4 and line 5.
Line 7: Line 7 automatically populates the total column with the cost-to-charge ratio determined by dividing line 6 by line 3.
Line 8: Line 8 automatically calculates costs for each population based on the cost-to-charge ratio. Charges from line 3 are multiplied by the cost-to-charge ratio in the total column of line 7.

A validation check appears below Part I to verify that total costs tie to the total direct and indirect costs applicable to CCBHC services (line 4).

Line 50: Enter the subtotal of direct costs for non-CCBHC services covered by Medicaid, excluding overhead and specify in the Comments tab.

The costs should be to support both Medicaid and non-Medicaid users. Anticipated costs are allowed for demonstration year 1 only. Demonstration year 2 requires actual data.
For example, this might include staffing costs for three social workers or other licensed clinicians to provide mobile crisis services 24 hours a day, with additional staffing as needed to accompany the primary clinician. This might be reduced by the amount that those staff can be used for other purposes when not providing mobile services. The CCBHC criteria (5.a.1) require the CCBHCs to collect, report and track cost data. Here, the development of anticipated costs is in lieu of actual costs during the first year of the program.

Line 3: Enter the total number of additional anticipated unique patient visit days for patients irrespective of payer receiving CCBHC demonstration services not included above. The additional visits should be for the anticipated increase in unique patients corresponding to the additional services costs identified in the anticipated costs tab. Anticipated visits are allowed for demonstration year 1 only. Demonstration year 2 requires actual data.
Line 4: Enter the total number of additional anticipated unique patient visit months for patients irrespective of payer receiving CCBHC demonstration services by population not included above. The additional visits should be for the anticipated increase in unique patients corresponding to the additional services costs identified in the anticipated costs tab. Anticipated visits are allowed for demonstration year 1 only. Demonstration year 2 requires actual data.

Changed the tabs for the Cost Report to the following order: Provider Information, Trial Balances, Trial Balance Reclassifications, Trial Balance Adjustments, Anticipated Costs, Indirect Cost Allocation, Allocation Description, Daily Visits, Monthly Visits, Services Provided, Comments, CC PPS-1 Rate, CC PPS-2 Rate, Certification

The order of the sections were moved around to reflect the recommended order in Table 2 of the Cost Report Instructions for completing the cost report.

Line 11: Enter “Yes” if the site operates as other than a CCBHC. Otherwise, enter “No.” If No is entered, skip lines 12 and 14.

Line 14: If the answer to Line 11 is Yes (the site operates as other than a CCBHC), enter the hours of operation and total hours for each day of the week that the site operates as other than a CCBHC. Note, the hours provided in line 13 and 14 may overlap if the site operates as a CCBHC and other than a CCBHC during the same time period. If the answer to line 12 is No, skip this line.

Line 15: List any excluded satellite facilities and reasons for exclusion.

Changed to "Use the CC PPS-1 Rate tab to calculate the daily rate to be finalized by the state. The daily rate is based on the expected costs of all demonstration services irrespective of payer. "

Changed to "Use the CC PPS-2 Rate tab to calculate a preliminary PPS rate based on costs for all CCBHC demonstration services provided to all CCBHC clinic users irrespective of payer. The calculation of the PPS rate is preliminary and will be finalized by the state in accordance with the state's policy concerning outlier payments.
Costs must be allocated to the standard and special populations identified in Section 10 (Monthly Visits tab) of this document. One acceptable method of allocating cost by population is multiplying a cost-to-charge ratio by charges incurred for each population. The cost-to-charge ratio represents total costs, including anticipated costs for all users regardless of payer divided by all charges for all users regardless of payer. Each individual charge is multiplied by the ratio to estimate the cost of performing each service. Those costs should be categorized by patient and evaluated to determine if costs exceed the outlier threshold.
The use of the cost-to-charge ratio requires uniform charges for comparable demonstration services. The state may require an attestation that the CCBHC is using a uniform charges each time the service is provided during the month. As a condition of participation in the demonstration program, CCBHCs must collect and report encounter, clinical outcome, and quality improvement data. CCBHC consumer claim or encounter data must be linkable to the consumer's pharmacy claims or utilization information, inpatient and outpatient claims, and any other claims or encounter data necessary to report the measures. The CCBHC should be recording this information per CCBHC criteria 5.a.4."

Part 1 Column Descriptions- ie: total charges and costs

Line 9: "Total allowable CCBHC costs" is automatically populated on this line from the allowable CCBHC costs on line 8 above."

Changed to Line 3: "Enter the total number of additional anticipated unique patient visit days for patients irrespective of payer receiving CCBHC demonstration services not included above. Anticipated visits are allowed for demonstration year 1 only. Demonstration year 2 requires actual data."

Changed to Line 5: "Total daily visits for patients receiving CCBHC services," which is calculated by adding the amounts on lines 1 through 3 above, is automatically populated on this line."

Changed to Line 3: "Enter the total number of additional anticipated unique patient visit months for patients irrespective of payer receiving CCBHC demonstration services not included above. Anticipated visits are allowed for demonstration year 1 only. Demonstration year 2 requires actual data."

Changed to Line 5: “Total months patients received CCBHC services,” which is calculated by adding the amounts on lines 1 through 3 above, is automatically populated on this line."

Changed to "This number represents the total quantity (units) of services provided, as opposed to the number of days that each patient received services as described in section 9 or the number of months that each patient received services as described in Section 10."

Table 2, column 1: **"Daily or Monthly** Visits"; Column 2: "Read Section 9 **or** 10…", and "Read Section 13 or 14…"

Each clinic filing under consolidated cost reporting must complete this section of the worksheet. Complete Part 2 for each site included in the consolidation. When more than one satellite site exists, create a new tab within the workbook labeled “Provider Information Cont.”. For each satellite site copy and paste all of Part 2 into the new tab and complete the form.

Complete Part 2 for each satellite site. When more than one satellite site exists, create a new tab within the workbook labeled “Services Provided Cont.”. For each satellite site copy and paste all of Part 2 into the new tab and complete the form.

Reason/Notes
All clinics must submit information that demonstrates qualified practitioners will be providing demonstration services. CMS believes the information provided in number 9 suffices and has modified the cost report by removing the names of supervisory personnel and their hours. This modification was made in response to feedback received from the National Council for Behavioral Health.
Using the cost-to-charge ratio approach should provide a consistent method for allocation of costs between population groups and reduce the burden on CCBHCs to produce data at the level described. CMS expects that charge data for each population group should be easier to access and report. The approach also allows for the inclusion of anticipated charges for CCBHC services not provided prior to the demonstration. The anticipated charges should only be used for demonstration year 1.
Added "outlier threshold" to column headers to clarify Added "outlier" before threshold throughout instructions for clarity.
The approach also allows for the inclusion of anticipated visits for CCBHC services not provided prior to the demonstration. The anticipated visits should only be used for demonstration year 1.
The approach also allows for the inclusion of anticipated visits for CCBHC services not provided prior to the demonstration. The anticipated visits should only be used for demonstration year 1.
Updated revision date
Because of the brief demonstration period, additional comments or requested changes to the cost report template or instructions are unfeasible.
Added additional instructions to allow for providers without NPIs in response to feedback received from the National Council for Behavioral Health.

All clinics must submit information that demonstrates qualified practitioners will be providing demonstration services. CMS believes the information provided in line 9 suffices and has modified the cost report by removing the names of supervisory personnel and their hours.	
This information, which excludes the hours associated with mobile crisis team, will assist in the evaluation of access to behavioral health services made available through the demonstration. CMS has modified the cost report instructions to clarify the hour of the mobile crisis team are excluded as the statute and implementing guidance from SAMHSA indicate that CCBHCs have 24-hour a day responsibilities and are not confined to delivering services within the four walls of the clinic. This clarification was made in response to feedback received from the National Council for Behavioral Health.	
Added statement that the hours may overlap that a faciltiy provides CCBHC and non-CCHBC services	
Updated Part 2 Text to match additional text added in Part 1	
To clarify PPS rate is preliminary, based on all clinic users regardless of payer, and for all CCBHC demonstration services.	

Using the cost-to-charge ratio approach should provide a consistent method for allocation of costs between population groups and reduce the burden on CCBHCs to produce data at the level described. CMS expects that charge data for each population group should be easier to access and report. The approach also allows for the inclusion of anticipated charges for CCBHC services not provided prior to the demonstration. The anticipated charges should only be used for demonstration year 1. We also clarifed that the PPS rates are preliminary, based on all clinic users regardless of payer, and for all CCBHC demonstration services.

Using the cost-to-charge ratio approach should provide a consistent method for allocation of costs between population groups and reduce the burden on CCBHCs to produce data at the level described. CMS expects that charge data for each population group should be easier to access and report. The approach also allows for the inclusion of anticipated charges for CCBHC services not provided prior to the demonstration. The anticipated charges should only be used for demonstration year 1.
The statute requires CCBHCs to screen for primary care conditions and a physician has an obligation to treat medical conditions that are brought to their attention. It is unrealistic for a physician to allocate that cost by the minute, therefore the example citing physician visits for physical care was removed. This modification was made in response to feedback received from the National Council for Behavioral Health.
Clarified that anticipated costs should only be used for setting PPS rates for demonstation year 1, since after demonstration year 1, actual data should be available.

The approach also allows for the inclusion of anticipated visits for CCBHC services not provided prior to the demonstration. The anticipated visits should only be used for demonstration year 1. Subsequent lines were renumbered to include this addition.
The approach also allows for the inclusion of anticipated visits for CCBHC services not provided prior to the demonstration. The anticipated visits should only be used for demonstration year 1. Subsequent lines were renumbered to include this addition.

The movement of the tabs supports the recommended order in Table 2 of the Cost Report Instructions for completing the cost report.

The movement of the sections support the recommended order in Table 2 of the Cost Report Instructions for completing the cost report.

The line numbers were corrected to accurately reflect the correct corresponding lines.

The word "over" replaced with "during" and "question" replaced with "line" to improve clarity in the instructions.

Language changed to improve clarity of instructions.

Language changed to improve clarity of instructions.

Paragraph reworded and organized to promote clarity in the cost report instructions.

Changed "charges" to "charges and costs" throughout the column descriptions for part 1 to reflect the headers in the cost report.

The line numbers were corrected to accurately reflect the correct corresponding line.

Sentences deleted and modified to improve clarity of instructions.

Replaced "thru" with formal spelling of "through"

Sentences deleted and modified to improve clarity of instructions.

Replaced "thru" with formal spelling of "through"

Section numbers changed to reflect new sections after movement in cost report instructions.

Updated for clarity so that Monthly/Daily matched Instructions sections and clarified that only 1 of the two sections needed to be read (based on the PPS method selected)

Added instructions for creating a new tab to capture additional satellite information. With the locked 508 version a user is not able to paste Part 2 below. However, they can add a new tab to include site specific information.

Updated instructions for including additional sites.