Cost Estimation When Time and Resources are Limited: The Brief DATCAP

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Abstract

The Drug Abuse Treatment Cost Analysis Program (DATCAP) was designed in the early 1990s as a research guide to collect and analyze financial data from addiction treatment programs. The addiction research community could clearly benefit from a version of the DATCAP that reduced the time and effort required for its administration without compromising the integrity of its cost estimates. This paper introduces the Brief DATCAP and presents some preliminary findings.

Initial feedback from respondents suggests that the Brief DATCAP is understandable, and easier and quicker to complete than the DATCAP. More importantly, preliminary results indicate that cost estimates from the Brief DATCAP differ from those of the longer DATCAP by less than 2 percent. These results have important research and policy implications because a shorter yet reasonably accurate cost instrument will enhance the feasibility and precision of future economic evaluations of addiction interventions.
I. Introduction

The foundation of the economic evaluation of any addiction treatment is a cost analysis of the services that define that treatment. A proper economic cost analysis is required to examine cost-effectiveness as well as the net benefits of alternative treatments or interventions. Unlike the outcomes side of program evaluation, instrument development has emerged only recently for cost analyses. Indeed, despite the use of various cost instruments in some evaluation studies (e.g., Anderson et al., 1998; Barnett et al., 2001; Capital Consulting Corporation, 1998; Cisler et al., 1998), the Drug Abuse Treatment Cost Analysis Program (DATCAP) is the only cost instrument that has undergone extensive testing, regular updates, and peer review (Alexandre et al., 2003; Bradley et al., 1994; Bray et al., 1996; French, Bradley, et al., 1994; French, Dunlap, et al., 1996; French, Dunlap, et al., 1998; French, Dunlap, et al., 1997; French & McGeary, 1997; French, Roebuck, et al., 2002; French, Sacks, et al., 1999; McCollister & French, 2002; McGeary, et al., 2000; Roebuck, French, & McLellan, 2003; Salomé & French, 2001; www.DATCAP.com). In addition to traditional cost analyses, the DATCAP has also been used along with other instruments to perform more advanced economic evaluations, including cost-effectiveness analysis and benefit-cost analysis (Alexandre et al., 2002; French, McCollister, Cacciola, et al., 2002; French, McCollister, Sacks, et al., 2002; French, Roebuck, et al., 2003; French, Salomé, & Carney, 2002; French, Salomé, et al., 2000; French, Salomé, Sindelar, et al., 2002; McCollister, French, Prendergast, et al., 2003; McCollister, French, Inciardi, et al., 2003).

Although the DATCAP conforms to the principles of economic cost analysis (Drummond et al., 1997; Gold et al., 1996) and has performed well in numerous evaluation studies, recent information indicates that modifications are necessary for some applications. At 26 pages, the
instrument is somewhat overwhelming for addiction program administrators who may have little or no familiarity with economic analysis. Many of these individuals are further discouraged by the increasing programmatic demands on their time and the shortage of support staff. Even with a fairly large cash incentive (e.g., $500), it has become increasingly difficult to enlist the support of program directors for a cost analysis employing the DATCAP. The primary reason for declining to participate was not a lack of interest or data sensitivity concerns, but a lack of available time to complete the DATCAP.

Another concern with administration of the DATCAP at multiple programs is facilitator burden. As stated in the DATCAP User’s Manual (French, 2002b), it is strongly recommended that an economist or similarly trained professional direct the data collection and analysis through a site visit and ongoing communication such as conference calls, emails, and telephone conversations. These activities can easily amount to 3 days or more if treatment administrators require extensive assistance to assemble data and comprehend the various measures and related economics principles of the questionnaire. A shorter instrument that is easier to understand and complete will certainly reduce the burden placed on the economist facilitator.

Despite the obvious advantages of a shorter and simplified DATCAP, such a pursuit would be futile if the resulting data were incomplete and/or misreported, leading to biased cost estimates. To investigate the feasibility, burden, and precision of a Brief DATCAP, we pilot tested the instrument at 5 substance abuse treatment programs. The programs were not selected randomly, but they do represent a range of different substance abuse interventions, settings, and clients. In addition, 3 of the 5 programs completed both the DATCAP and Brief DATCAP, which allowed us to assess any differences in cost estimates between the two instruments. Ultimately, we anticipate that this research project will lead to a cost estimation instrument that
is more accommodating to program and clinical personnel without sacrificing economic estimation objectives.

II. Treatment Cost Estimation

DATCAP History

The DATCAP was created and launched in the early 1990s (Bradley, French, & Rachal, 1994; French, Bradley, et al., 1994) and has since undergone extensive revisions. Currently, the eighth edition of both the DATCAP Program Version (French, 2002a) and the DATCAP User's Manual (French, 2002b) can be downloaded in Adobe Acrobat format (.pdf) from www.DATCAP.com or requested by mail. In addition to the recently created Brief DATCAP, a Client DATCAP was also developed to calculate the cost of treatment incurred by clients (Salome, French, et al., 2003). Preliminary versions of these instruments are also available on the website or by written request. The DATCAP instruments are in the public domain, but it is recommended that an experienced economist administer them.

The DATCAP is a data collection instrument and interview guide designed to estimate the costs of a substance abuse treatment program, defined as a single intervention (i.e., a facility offering both outpatient and inpatient treatment services would require the completion of two DATCAPs). Based upon standard accounting and economic principles, the instrument measures both accounting and economic costs. Accounting costs represent the actual expenditures of a treatment program and the depreciation of its resources. Economic costs represent the full value of all resources (i.e., opportunity costs), regardless of whether a direct expenditure is involved. In general, economic costs are equal to accounting costs plus the incremental value of those resources that are either partially subsidized or used free of charge by the treatment program (French, 2002b). The DATCAP is appropriate for economic cost estimation of most treatment
modalities in most social service settings. The instrument is intended to collect and organize detailed information on resources used in service delivery and their associated costs. Resource categories include personnel, contracted services, buildings and facilities, equipment, supplies and materials, and miscellaneous items. Additionally, the DATCAP gathers data on program revenues and client caseflows.

**DATCAP Administration**

Administration of the DATCAP is generally a collaborative effort involving an economist and various members of the treatment program's staff (e.g., administrators, therapist coordinators, and accounting/finance personnel). The process begins by issuing DATCAP materials to program personnel who are most familiar with the operations and financing of the facility. After these personnel have had adequate time to review the materials, several conference calls are conducted between them and the DATCAP-trained health economists to formulate strategies for preliminary data collection and to answer questions regarding the completion of the DATCAP. Generally, program personnel are offered guidance about the type and source of information to gather for administration of the DATCAP. Besides the familiar categories of program personnel, equipment, and facilities, indirect costs such as support personnel, services, contractors, and shared equipment are emphasized. The proper inclusion of these items is critical for the accuracy of the resource use and cost estimates. A site visit/tour is then conducted by the DATCAP administrator, during which face-to-face meetings are held and the instrument is completed. The purpose of the site visit is to ensure that certain important elements associated with the operation and financing of the treatment program are not inadvertently overlooked by either the provider or the researchers.
Data Assembly Procedures

As DATCAP interviews are completed, the resulting data are entered into a supplementary Microsoft Excel spreadsheet template that mirrors the hard copy version of the instrument. This spreadsheet generates a 2-page Results Summary Report, which provides the analysts and the program director with key statistics from the cost evaluation, including total annual economic cost for the program, weekly economic cost per client, and total economic cost per treatment episode.

Elements of the Brief DATCAP

One of the top priorities in the creation of the Brief DATCAP was to retain the key elements of the DATCAP. That is, the Brief DATCAP needed to be structured along the same resource categories, to produce an identical 2-page Results Summary Report through a corresponding spreadsheet program, and to include a User’s Manual to answer any questions and generally to assist program personnel. In addition to these features, we also developed an electronic version of the Brief DATCAP, giving respondents the option of entering all information directly from a personal computer rather than on a hard copy of the instrument. This enhancement assists both program personnel and the DATCAP administrators by improving the efficiency and clarity of data entry.

Regarding the specific changes from the DATCAP to the Brief DATCAP, some were cosmetic or editorial in nature while others were more substantive. The list below summarizes all changes made, organized by sections of the instrument.

Section A: Program Revenue
• All of the program revenue questions were deleted. This information is useful for describing the financial operations of the program, but it is not necessary for cost estimation.

Section B: Client Information

• “Average client-to-counselor/therapist caseload (ratio)” was deleted. This question is not necessary for cost estimation.

• Client information is requested for the current fiscal year only instead of the current, prior, and next fiscal years.

Section C: Personnel

• Total cost of employee benefits is now requested in the aggregate rather than by individual benefit categories (e.g., FICA, health insurance, etc.)

Section D: Contracted Services

• No changes in this section.

Section E: Buildings and Facilities

• Questions about the use of buildings and facilities during the previous and next fiscal years were deleted.

• Questions about specific uses of the buildings and facilities were deleted.

• Questions about the annual lease/rental price per square foot and the estimated fair market value per square foot were combined into one question. A total of 11 questions in this section was reduced to 5.

• The number of pages in the instrument was reduced considerably by removing extra copies of the Buildings and Facilities section and requesting that the
respondent make additional copies of this section for each building/facility
operated by the program.

Section F: Equipment

- All detailed and lengthy questions about the units of equipment by category (i.e.,
  office, computers, electronic, medical, recreational, child care, residential,
  vehicles, miscellaneous), purchase price, purchase year, and condition were
  deleted. A single replacement question was added pertaining to depreciation
  expenses for all equipment.

Section G: Supplies and Materials

- Rather than asking for the cost of supplies and materials for narrow categories
  (e.g., medical, office, housekeeping), a single question now asks about the
  aggregated cost for all supplies and materials.

- A similar change was executed for the estimated market value (cost) of supplies
  and materials used by the treatment program free of charge.

Section H: Miscellaneous Resources and Costs

- No changes in this section.

Section I: Resources and Costs Not Recorded Elsewhere

- This section was eliminated because past administrations of the DATCAP
  indicated that very few programs entered information in this section.

Although these changes to the DATCAP may seem abundant, it is important to note that
the sections and questions that were preserved in the Brief DATCAP represent the vast majority
of costs at most programs. For example, Sections C, D, E, and H were retained in their original
form or with minor changes. Summary statistics from 85 completed DATCAPs (Roebuck,
French, & McLellan, 2003) reveal that these sections in most cases comprise over 90% of the total annual cost of treatment. Thus, it is unlikely that the Brief DATCAP will significantly alter the estimated cost of addiction treatment derived from the DATCAP.

**Description of Programs and Clients**

As noted earlier, program selection for this pilot study was conducted purposely, based largely on the timing of ongoing research projects. Nevertheless, the programs represent a range of outpatient services for both adult and adolescent treatment clients. Each of the 5 participating programs is described below, but the descriptions are kept fairly general to preserve program anonymity.

Program 1 is an intensive outpatient program for adolescent treatment clients. It is located in the Southeastern U.S., and its financial structure is private, not for profit. In fiscal year 2002 it served a total of 15 adolescent clients. The average daily census was 10.4 clients and the median length of stay was 29.7 weeks.

Program 2 is also an intensive outpatient program for adolescent treatment clients. It is located in the Mountain West U.S., and its financial structure is public, not for profit. In fiscal year 2002 it served a total of 44 adolescent clients. The average daily census was 13.1 clients and the median length of stay was 15 weeks.

Program 3 is an outpatient program for both adult and adolescent treatment clients. It is located in the Midwestern U.S., and its financial structure is public, not for profit. In fiscal year 2002 it served a total of 102 clients. The average daily census was 46 clients and the median length of stay was 15.4 weeks.

Program 4 is also an outpatient program for both adult and adolescent treatment clients. It is located in the Midwestern U.S., and its financial structure is private, not for profit. In fiscal
year 2002 it served a total of 29 clients. The average daily census was 7.6 clients and the median length of stay was 10.8 weeks.

Program 5 is an adolescent outpatient program located in the Southwestern U.S., and its financial structure is public, not for profit. In fiscal year 2002 it served a total of 38 clients. The average daily census was 8.5 clients and the median length of stay was 12 weeks.

III. Results

Cost data from this pilot study provided financial information from 5 separate programs, including 3 programs that completed both the DATCAP and the Brief DATCAP. Although the cost estimates are useful for demonstrating the feasibility and precision of the Brief DATCAP, these estimates are not necessarily representative of all outpatient treatment in the U.S. and thus should not be used for any type of policy analysis in this regard. Referring to Table 1, regardless of service delivery or client orientation, personnel was the dominant resource category with over 64% of total annual cost at each of these programs. The rest of the resource categories had less consistency in distribution of costs across programs.

Based on the Brief DATCAP data, total annual economic cost ranged from at $80,150 at Program 4 to $297,798 at Program 3. At the 3 programs that also completed the DATCAP, total annual economic cost was almost identical. Specifically, compared to the Brief DATCAP, DATCAP estimates were the same at Program 1, $4,190 lower (1.7%) at Program 2, and $1,092 higher (1.1%) at Program 5.

Visual comparisons between the DATCAP and Brief DATCAP data at Programs 1, 2, and 5 are presented in Figure 1. This graphic shows the distribution of total annual cost across the 6 resource categories using both the DATCAP and Brief DATCAP instruments. Regardless of the resource category, these distributions were very similar for both instruments.
Not surprisingly, weekly economic cost per client was lower at the standard outpatient programs ($124-$224) relative to the intensive outpatient programs ($361-$391). Similarly, economic cost per treatment episode ranged between $1,916 and $2,688 for the standard outpatient programs, and between $5,419 and $11,603 for the intensive outpatient programs. Again, summary cost statistics from the DATCAP never displayed more than 2% variation from the corresponding summary cost statistics from the Brief DATCAP.

Although the sample size was relatively small for this pilot study, it is instructive to report some preliminary qualitative data as well. Compared to a 2-3 day full-time equivalent (FTE) investment for most programs to complete the DATCAP, the Brief DATCAP required about a 1 day FTE investment. Input and assistance from an economist was not measurably different for each instrument, however. Informal discussion with all 5 programs that completed the Brief DATCAP conveyed that the instrument was well organized and understandable, and the corresponding data were fairly easy to assemble.

IV. Discussion

The DATCAP collects resource use and cost data from the program perspective and has been utilized in numerous economic evaluation studies. While practical and expedient for analyzing a small number of treatment programs with well-organized data, the administration of the DATCAP becomes very tedious and expensive when a larger number of programs are under consideration and/or records are not ideal or easily accessible. In addition, treatment administrators have revealed in recent discussions that they have limited time for discretionary activities such as program evaluation. For this reason, and in the interest of reducing respondent burden, they have repeatedly expressed a desire for a shorter version of the DATCAP instrument. Given these time and resource constraints, the addiction research community could clearly
benefit from a version of the DATCAP that reduced the time and effort required for its administration without compromising the integrity of its cost estimates.

The 1st edition of the Brief DATCAP is available from the corresponding author by mail or by download at www.DATCAP.com. While the initial applications of and preliminary findings from the Brief DATCAP are encouraging, it is clearly necessary to administer and evaluate the instrument in more settings, more programs and modalities, and with different client samples. In addition to variety in modalities and client mix, further study should make use of programs of varying size in recognition of the comparatively small programs included in the present study. Indeed, we strongly encourage other researchers to experiment with the instrument and publish their findings. As with the DATCAP, we would like to assemble a long list of cost estimates from a variety of different programs so that the Brief DATCAP can serve as both a research tool and a policy aid (see Roebuck, French, & McLellan, 2003).

Given the extensive testing and application of the DATCAP, one might question the viability of a substitute instrument such as the Brief DATCAP. History will be the best judge, but it is our hope and expectation that the Brief DATCAP will make economic evaluation research more appealing to addiction treatment programs that may have been reluctant to complete the DATCAP.

The presence of two cost instruments on the DATCAP web page occasionally leads respondents to inquire whether it is best to complete the DATCAP or the Brief DATCAP. If time and resources permit, we always direct the respondent to the DATCAP because the methods are sound and the information can be used for a variety of purposes. But if the respondent has limited time, resources, and/or detailed records, then we encourage the use of the Brief DATCAP, especially if the sole objective is to obtain summary cost statistics. To expedite the
completion of any DATCAP instrument in the future, we plan to add a Frequently Asked Questions (FAQs) section to the DATCAP web page and to have this information easily accessible through a hyperlink on the main screen.

V. Conclusion

The dual objective of this paper was to launch Edition 1 of the Brief DATCAP and to present pilot study findings from 5 addiction programs. A small sample such as this does not definitively validate or endorse an instrument, but the results suggest that the Brief DATCAP is easy to understand, agreeable to program directors, and similar to the DATCAP in summary cost estimates. Like the DATCAP, we hope that other analysts will join us in future applications of the Brief DATCAP so that the instrument can be incrementally improved and widely utilized.

Acknowledgements: Financial assistance for this study was provided by the National Institute on Drug Abuse (grant numbers 1R01 DA11506 and 3P50 DA07705) and the National Institute on Alcoholism and Alcohol Abuse (1R01 AA13167). We are grateful to Jody Sindelar and Silvana Zavala for helpful suggestions on earlier versions of the Brief DATCAP; Mark Godley, Michael Boyle, Holly Waldron, Paula Riggs, Michael Miller, Howard Liddle, Gayle Dakof, Cindy Rowe, and Craig Henderson for assistance with data collection, and William Russell and Carmen Martinez for administrative and editorial assistance. The authors are entirely responsible for the research conducted in this paper and their position or opinions do not necessarily represent those of the National Institute on Drug Abuse, the National Institute on Alcoholism and Alcohol Abuse, the University of Miami, Caremark, or the Treatment Research Institute.
References


Table 1. Comparison of Treatment Characteristics and Costs from the Brief DATCAP (2002 Dollars)

<table>
<thead>
<tr>
<th>Treatment Program Characteristics</th>
<th>Program 1</th>
<th>Program 2</th>
<th>Program 3</th>
<th>Program 4</th>
<th>Program 5</th>
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<tr>
<td><strong>Modality</strong></td>
<td>AIOP</td>
<td>AIOP</td>
<td>OP</td>
<td>OP</td>
<td>AOP</td>
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<td>Financial Structure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Clients Served</td>
<td>15</td>
<td>44</td>
<td>102</td>
<td>29</td>
<td>38</td>
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<tr>
<td>Average Daily Census</td>
<td>10.4</td>
<td>13.1</td>
<td>46.0</td>
<td>7.6</td>
<td>8.5</td>
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<tr>
<td>Median Length of Stay (weeks)</td>
<td>29.7</td>
<td>15.0</td>
<td>15.4</td>
<td>10.8</td>
<td>12.0</td>
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<td><strong>Treatment Program Costs</strong></td>
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<td>Personnel</td>
<td>$184,551</td>
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<td>$191,199</td>
<td>$64,857</td>
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<td>(0.70)</td>
<td>(0.64)</td>
<td>(0.81)</td>
<td>(0.85)</td>
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<td>(0.06)</td>
<td>(0.14)</td>
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<td>Buildings and Facilities</td>
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<td>$24,401</td>
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<td>(0.02)</td>
<td>(0.08)</td>
<td>(0.02)</td>
<td>(0.07)</td>
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<td>Major Equipment</td>
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<td>$5,318</td>
<td>$160</td>
<td>$0</td>
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<td>(0.03)</td>
<td>(0.02)</td>
<td>(0.00)</td>
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<td>Supplies and Materials</td>
<td>$1,905</td>
<td>$13,992</td>
<td>$5,828</td>
<td>$1,051</td>
<td>$3,493</td>
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<td></td>
<td>(0.01)</td>
<td>(0.06)</td>
<td>(0.02)</td>
<td>(0.01)</td>
<td>(0.04)</td>
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<td>Miscellaneous</td>
<td>$7,789</td>
<td>$32,517</td>
<td>$29,560</td>
<td>$12,578</td>
<td>$3,221</td>
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<td></td>
<td>(0.04)</td>
<td>(0.13)</td>
<td>(0.10)</td>
<td>(0.16)</td>
<td>(0.03)</td>
</tr>
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</table>

**Brief DATCAP Summary Statistics**

<p>| | | | | | |</p>
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<th></th>
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<tr>
<td><strong>Total Annual Economic Cost</strong></td>
<td>$212,583</td>
<td>$246,773</td>
<td>$297,798</td>
<td>$80,150</td>
<td>$99,623</td>
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<td></td>
<td>{$212,583}</td>
<td>{$242,583}</td>
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<td>{N/A}</td>
<td>{$100,715}</td>
</tr>
<tr>
<td><strong>Weekly Economic Cost per Client</strong></td>
<td>$391</td>
<td>$361</td>
<td>$124</td>
<td>$202</td>
<td>$224</td>
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<td></td>
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<td>{$355}</td>
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<td>{N/A}</td>
<td>{$226}</td>
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<tr>
<td><strong>Economic Cost per Treatment Episode</strong></td>
<td>$11,603</td>
<td>$5,419</td>
<td>$1,916</td>
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<td>{$2,718}</td>
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</table>

Notes: All costs are reported in 2002 dollars.
AIOP = Adolescent Intensive Outpatient Program; OP = Standard Outpatient Program; AOP = Adolescent Standard Outpatient Program
1Proportions of Total Annual Economic Cost reported in parentheses.
2Summary statistics from the DATCAP are reported in braces.
3Weekly Economic Cost per Client = Total Annual Economic Cost / Average Daily Census / 52.14 weeks.
4Economic Cost per Treatment Episode = Weekly Economic Cost per Client x Median Length of Stay (weeks)
Figure 1. Comparisons of Cost Categories for Programs Completing Both the DATCAP and Brief DATCAP

<table>
<thead>
<tr>
<th></th>
<th>Program 1</th>
<th>Program 2</th>
<th>Program 5</th>
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</thead>
<tbody>
<tr>
<td><strong>Brief DATCAP</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>3.66%</td>
<td>13.18%</td>
<td>0.64%</td>
</tr>
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<td>Supplies and Materials</td>
<td>0.90%</td>
<td>5.67%</td>
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</tr>
<tr>
<td>Major Equipment</td>
<td>0.00%</td>
<td>3.21%</td>
<td>1.66%</td>
</tr>
<tr>
<td>Buildings and Facilities</td>
<td>6.60%</td>
<td>2.41%</td>
<td>6.70%</td>
</tr>
<tr>
<td>Contracted Services</td>
<td>2.03%</td>
<td>5.69%</td>
<td>1.52%</td>
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<tr>
<td>Personnel</td>
<td>86.81%</td>
<td>69.85%</td>
<td>87.54%</td>
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<td><strong>DATCAP</strong></td>
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<tr>
<td>Miscellaneous</td>
<td>3.66%</td>
<td>13.28%</td>
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<td>Supplies and Materials</td>
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<td>Major Equipment</td>
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<td>Buildings and Facilities</td>
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