

**SUBSTANCE ABUSE & MENTAL HEALTH SERVICES
PROJECTED COST CENTER OPERATING AND CAPITAL BUDGET**

AGENCY: _____ DATE PREPARED: _____

INITIAL: 0
FINAL: 0

CONTRACT #: _____

BUDGET PERIOD: From _____ To: _____

PART I: PROJECTED FUNDING SOURCES & REVENUES

FUNDING SOURCES & REVENUES A	STATE-DESIGNATED SAMH COST CENTERS							Total for State SAMH-Funded Cost Centers (C ₁ +...+C ₄) D	Total for Non-State-Funded SAMH Cost Centers E	Tot. for All State-Designated SAMH Cost Centers (D+E) F	Non-SAMH Cost Center G	Total Funding (F+G) H
	STATE SAMH-FUNDED COST CENTERS											
	Program 1											
	Ex: Assessment B _{1-a}	Ex: Case Management B _{1-a}	Ex: Outpatient B _{1-b}	Ex: Prevention B _{1-c}	Ex: Residential I B _{1-d}	Ex: Respite B _{1-e}	Ex: Aftercare B _{1-f}					
IA. TOTAL STATE SAMH FUNDING												
(1) From the District funding this contract								-		-		-
(2) From Other Districts										-		-
IB. OTHER GOVT. FUNDING												
(1) Other State Agency Funding										-		-
(2) Medicaid										-		-
(3) Local Government										-		-
(4) Federal Grants and Contracts										-		-
(5) In-kind from local govt. only										-		-
TOT. OTHER GOVT. FUNDING =												
	=====	=====	=====	=====	=====	=====	=====	=====	=====	=====	=====	=====
IC. ALL OTHER REVENUES												
(1) 1st & 2nd Party Payments										-		-
(2) 3rd Party Payments (except Medicare)										-		-
(3) Medicare										-		-
(4) Contributions and Donations										-		-
(5) Other										-		-
(6) In-kind										-		-
TOT. ALL OTHER REVENUES =												
	=====	=====	=====	=====	=====	=====	=====	=====	=====	=====	=====	=====
TOTAL PROJECTED FUNDING =												
	=====	=====	=====	=====	=====	=====	=====	=====	=====	=====	=====	=====

**SUBSTANCE ABUSE & MENTAL HEALTH SERVICES
PROJECTED COST CENTER OPERATING AND CAPITAL BUDGET**

AGENCY: _____ DATE PREPARED: _____

INITIAL: 0
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BUDGET PERIOD: From _____ To: _____

PART II: PROJECTED EXPENSES

EXPENSE CATEGORIES A	STATE-DESIGNATED SAMH COST CENTERS											Non-SAMH Cost Center G	Other Support Costs (optional) H	Administration I	Total Expenses (F+G+H+I) J		
	STATE SAMH-FUNDED COST CENTERS																
	Program 1																
	Ex: Assessment B _{1-a}	Ex: Case Management B _{1-a}	Ex: Outpatient B _{1-b}	Ex: Prevention B _{2-a}	Ex: Residential I B _{2-a}	Ex: Respite B _{2-b}	Intervention B _{3-a}	Total for State SAMH-Funded Cost Centers (C ₁ +...+C ₄) D	Total for Non-State-Funded SAMH Cost Centers E	Tot. for All State-Designated SAMH Cost Centers (D+E) F	*except IIC & IID						
IIA. PERSONNEL EXPENSES																	
(1) Salaries	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
(2) Fringe Benefits	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
TOTAL PERSONNEL EXPENSES =	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
IIB. OTHER EXPENSES																	
(1) Building Occupancy	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
(2) Professional Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
(3) Travel	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
(4) Equipment	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
(5) Client Support	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
(6) Medical and Pharmacy	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
(7) Subcontracted Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
(8) Insurance	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
(9) Interest Paid	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
(10) Operating Supplies & Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
(11) Other	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
(12) Donated Items	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
TOTAL OTHER EXPENSES =	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
TOT. PERSONNEL & OTH. EXP. =	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
IIC. DISTRIBUTED INDIRECT COSTS																	
(a) Other Support Costs (Optional)	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
(b) Administration	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
TOT. DISTR'D INDIRECT COSTS =	-	-	-	-	-	-	-	-	-	-	-	XXXXXXXXXX	XXXXXXXXXX	-			
TOTAL PROJECTED OPER. EXPENSES =	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
IID. UNALLOWABLE COSTS																	
	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
TOTAL SAMH LINES OF CREDIT EQUIVALENT =	-	-	-	-	-	-	-	-	-	-	-	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX			
TOT. ALLOWABLE PROJ'D OPERATING EXP., Excluding SAMH Credit Equivalent =	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
IIF. CAPITAL EXPENDITURES	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$			
IIG. BUDGET NARRATIVE (attach separate set of workpapers)																	
PART III: CERTIFICATION																	
I certify the above to be an accurate projection and in agreement with this agency's records and with the terms of this agency's contract with the department.																	
<table border="0" style="width:100%"> <tr> <td style="width:33%">Signature</td> <td style="width:33%">Title</td> <td style="width:33%">Date</td> </tr> </table>															Signature	Title	Date
Signature	Title	Date															