Please Check State Agency:
____ OMH
____ OMRDD
____ OASAS

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 1999 to December 31, 1999

SCHEDULE DMH-3
AID TO LOCALITIES AND DIRECT CONTRACTS
PROGRAM FUNDING SOURCE SUMMARY

AGENCY NAME:_____ USE WHOLE DOLLARS. PLEASE CHECK: ESTIMATED CLAIM ____

AGENCY CODE:_____ COUNTY NAME & CODE: _____(____) FINAL CLAIM ____

Line No.	COLUMN NUMBER / ITEM DESCRIPTION		Cost Codes										TOTAL
1	Accounting Method												
2	Program Type		00073										
3	Program Code		00013										
4	Total Persons Served/Month		00220										
5	Total Units of Service		00999										
6	Gross Cost/Unit of Service		70999										
7	Net Cost/Unit of Service		71999										
8	Please Check:			( )NON-PARTICIPANT SPECIFIC METHODOLOGY				( )PARTICIPANT SPECIFIC METHODOLOGY					
9	A. Funding Source Code (Local Assistance)	Index (OMH/OASAS only)		001		001		001		001		001	
10	Number Persons Served/Month		00260										
11	Number Units of Service		00250										
12	Total Adjusted Expenses		50999										
13	Less Applied Net Revenue		61999										
14	Net Operating Costs		62999										
15	Contract Number		00201										
16	B. Funding Source Code	Index (OMH/OASAS only)											
17	Number Persons Served/Month		00261										
18	Number Units of Service		00251										
19	Total Adjusted Expenses		50998										
20	Less Applied Net Revenue		61998										
21	Net Operating Costs		62998										
22	Contract Number		00202										
23	C. Funding Source Code	Index (OMH/OASAS only)											
24	Number Persons Served/Month		00262										
25	Number Units of Service		00252										
26	Total Adjusted Expenses		50997										
27	Less Applied Net Revenue		61997										
28	Net Operating Costs		62997										
29	Contract Number		00203										
	D. Totals From A-C Above												
30	Total Adjusted Expenses		51999										
31	Less Net Revenue		63999										
32	Net Operating Costs		52999										