

Provider Agency Name and Address:

Health Planning Council of Northeast Florida
 644 Cesery Blvd. #210
 Jacksonville, FL 32211

DEPARTMENT OF HEALTH
PATIENT CARE NETWORK-GENERAL REVENUE
 Monthly Expenditure and Reimbursement Report

From: 04-01-2009 to 04-30-2009

Contract No. CODK1



Preparer's Name: James Allen
 Phone Number: (904) 723-2162 ext.106

ORG: _____

OCA: _____ EO: _____

A. ADMINISTRATIVE BUDGET

	Original Amount	Approved Budget	Expenditures This Report	Expenditures Year-To-Date	Contract Balance
1. Salaries					
2. Fringe Benefits					
3. Travel					
4. Office Expenses					
5. Equipment					
6. Other--Audit Fees					
Subtotal Administrative Budget	16,298.00	0.00	1,339.31	13,619.42	2,678.58

B. DIRECT CARE

	Number of Clients Served	Number of Units of Service	Original Amount	Approved Budget	Expenditures This Report	Expenditures Year-To-Date	Contract Balance
7. Ambulatory - Outpatient Care			57,600.00		236.00	11,192.54	46,407.46
8. Buddy/Companion Services							
9. Case Management							0.00
10. Child Care Services							
11. Child Welfare Services							
12. Client Advocacy							
13. Day or Respite Care							
14. Drug Reimbursement (Local Program)			19,200.00		151.04	151.04	19,048.96
15. Early Intervention Services							
16. Food Bank/Nutritional Supplements			960.00			900.00	60.00
17. Health Education/Risk Reduction							
18. Health Insurance							0.00
19. Home Health Care							
20. Hospice Services - Home Based							
21. Hospice Services - Residential Care							
22. Housing Assistance (Not HOPWA)							
23. Legal Services							
24. Mental Health Services			960.00		952.33	952.33	7.67
25. Nutritional Counseling							
26. Oral Health Care			28,800.00		2,035.00	2,035.00	26,765.00
27. Other Health Care (Specify)							
28. Other Support Services (Specify)							
29. Outreach Services							
30. Permanency Planning							
31. Psychosocial Support Services							
32. Referral							

**DEPARTMENT OF HEALTH
PATIENT CARE NETWORK-GENERAL REVENUE
Monthly Expenditure and Reimbursement Report**



Provider Agency Name and Address:

Health Planning Council of Northeast Florida
644 Cesery Blvd. #210
Jacksonville, FL 32211

From: 04-01-2009 to 04-30-2009

Contract No. CODK1

Preparer's Name: James Allen
Phone Number: (904) 723-2162

ORG: _____

OCA: _____ EO: _____

	Number of Clients Served	Number of Units of Service	Original Amount	Approved Budget	Expenditures This Report	Expenditures Year-To-Date	Contract Balance
Direct Care - Continued:							
33. Rehabilitation Services							
34. Substance Abuse Services - Outpatient			960.00		65.00	65.00	895.00
35. Substance Abuse Services - Residential							
36. Transportation			595.00				595.00
37. Treatment Adherence Services							
38. Hospital Services							
39. Residential Care (Adult/Child)							
40. Nursing Home Care							
Subtotal Direct Care	0	0	109,075.00	0.00	3,439.37	15,295.91	93,779.09

C. PROGRAM SUPPORT - STATE PRIORITIES

41. Capacity Building							
42. Case Management Coordination							
43. Developing Standards of Care							
44. Evaluation of Cost Effectiveness							
45. Needs Assessment							
46. Other Program Support - State Priorities (Specify)							
44. Outcome Assessment							
48. Planning and Development							
49. Program Evaluation							
50. Quality Assurance							
51. Technical Assistance							
Subtotal Program Support - State Priorities			0.00	0.00	0.00	0.00	0.00
TOTAL SECTIONS A, B AND C			125,373.00	0.00	4,778.68	28,915.33	96,457.67

D. ADVANCE(S) INFORMATION

Total Advances	_____	Total Contract Amount	125,373.00
Previous Reductions	_____	Expenditures Year -To-Date	28,915.33
Current Reductions	_____	UNPAID Advances	0.00
Remaining Advances	0.00	Balance to Draw	96,457.67
Total Expenditures This Period		4,778.68	Type of Request:
Less Advances Paid This Period		0.00	Regular <input checked="" type="checkbox"/>
AMOUNT OF FUNDS REQUESTED THIS REPORT		4,778.68	Final <input type="checkbox"/>

I certify that the above report is a true, accurate and correct reflection of the activities of this period; and that the expenditures reported are made only for items which are allowable and directly related to the purpose of this referenced contract.

Signature and Title of Provider Agency Official _____ Date _____ Contract Manager's Signature _____ Date _____

Contract Manager's Supervisor Signature _____ Date _____

Provider Agency Name and Address:

Health Planning Council of Northeast Florida
 644 Cesery Blvd. #210
 Jacksonville, FL 32211

DEPARTMENT OF HEALTH
PATIENT CARE NETWORK-GENERAL REVENUE
 Monthly Expenditure and Reimbursement Report

From: 03-01-2009 to 03-31-2009

Contract No. CODK1



Preparer's Name: James Allen
 Phone Number: (904) 723-2162 ext.106

ORG: _____

OCA: _____ EO: _____

A. ADMINISTRATIVE BUDGET

	Original Amount	Approved Budget	Expenditures This Report	Expenditures Year-To-Date	Contract Balance
1. Salaries					
2. Fringe Benefits					
3. Travel					
4. Office Expenses					
5. Equipment					
6. Other--Audit Fees					
Subtotal Administrative Budget	16,298.00	0.00	1,339.31	12,280.11	4,017.89

B. DIRECT CARE

	Number of Clients Served	Number of Units of Service	Original Amount	Approved Budget	Expenditures This Report	Expenditures Year-To-Date	Contract Balance
7. Ambulatory - Outpatient Care	1	1	57,600.00		50.58	10,956.54	46,643.46
8. Buddy/Companion Services							
9. Case Management							0.00
10. Child Care Services							
11. Child Welfare Services							
12. Client Advocacy							
13. Day or Respite Care							
14. Drug Reimbursement (Local Program)			19,200.00				19,200.00
15. Early Intervention Services							
16. Food Bank/Nutritional Supplements			960.00			900.00	60.00
17. Health Education/Risk Reduction							
18. Health Insurance							0.00
19. Home Health Care							
20. Hospice Services - Home Based							
21. Hospice Services - Residential Care							
22. Housing Assistance (Not HOPWA)							
23. Legal Services							
24. Mental Health Services			960.00				960.00
25. Nutritional Counseling							
26. Oral Health Care			28,800.00				28,800.00
27. Other Health Care (Specify)							
28. Other Support Services (Specify)							
29. Outreach Services							
30. Permanency Planning							
31. Psychosocial Support Services							
32. Referral							

**DEPARTMENT OF HEALTH
PATIENT CARE NETWORK-GENERAL REVENUE
Monthly Expenditure and Reimbursement Report**



Provider Agency Name and Address:

Health Planning Council of Northeast Florida
644 Cesery Blvd. #210
Jacksonville, FL 32211

From: 03-01-2009 to 03-31-2009

Contract No. CODK1

Preparer's Name: James Allen
Phone Number: (904) 723-2162

ORG: _____

OCA: _____ EO: _____

	Number of Clients Served	Number of Units of Service	Original Amount	Approved Budget	Expenditures This Report	Expenditures Year-To-Date	Contract Balance
Direct Care - Continued:							
33. Rehabilitation Services							
34. Substance Abuse Services - Outpatient			960.00				960.00
35. Substance Abuse Services - Residential							
36. Transportation			595.00				595.00
37. Treatment Adherence Services							
38. Hospital Services							
39. Residential Care (Adult/Child)							
40. Nursing Home Care							
Subtotal Direct Care	1	1	109,075.00	0.00	50.58	11,856.54	97,218.46

C. PROGRAM SUPPORT - STATE PRIORITIES

41. Capacity Building							
42. Case Management Coordination							
43. Developing Standards of Care							
44. Evaluation of Cost Effectiveness							
45. Needs Assessment							
46. Other Program Support - State Priorities (Specify)							
44. Outcome Assessment							
48. Planning and Development							
49. Program Evaluation							
50. Quality Assurance							
51. Technical Assistance							
Subtotal Program Support - State Priorities			0.00	0.00	0.00	0.00	0.00
TOTAL SECTIONS A, B AND C			125,373.00	0.00	1,389.89	24,136.65	101,236.35

D. ADVANCE(S) INFORMATION

Total Advances _____	Total Contract Amount	125,373.00
Previous Reductions _____	Expenditures Year -To-Date	24,136.65
Current Reductions _____	UNPAID Advances	0.00
Remaining Advances <u>0.00</u>	Balance to Draw	101,236.35
Total Expenditures This Period	1,389.89	Type of Request:
Less Advances Paid This Period	0.00	Regular <input checked="" type="checkbox"/>
AMOUNT OF FUNDS REQUESTED THIS REPORT	1,389.89	Final <input type="checkbox"/>

I certify that the above report is a true, accurate and correct reflection of the activities of this period; and that the expenditures reported are made only for items which are allowable and directly related to the purpose of this referenced contract.

Signature and Title of Provider Agency Official _____	Date _____	Contract Manager's Signature _____	Date _____
		Contract Manager's Supervisor Signature _____	Date _____

Provider Agency Name and Address:

Health Planning Council of Northeast Florida
 644 Cesery Blvd. #210
 Jacksonville, FL 32211

DEPARTMENT OF HEALTH
PATIENT CARE NETWORK-GENERAL REVENUE
 Monthly Expenditure and Reimbursement Report

From: 02-01-2009 to 02-28-2009

Contract No. CODK1



Preparer's Name: James Allen
 Phone Number: (904) 723-2162 ext.106

ORG: _____

OCA: _____ EO: _____

A. ADMINISTRATIVE BUDGET

	Original Amount	Approved Budget	Expenditures This Report	Expenditures Year-To-Date	Contract Balance
1. Salaries					
2. Fringe Benefits					
3. Travel					
4. Office Expenses					
5. Equipment					
6. Other--Audit Fees					
Subtotal Administrative Budget	16,298.00	0.00	1,339.31	10,940.80	5,357.20

B. DIRECT CARE

	Number of Clients Served	Number of Units of Service	Original Amount	Approved Budget	Expenditures This Report	Expenditures Year-To-Date	Contract Balance
7. Ambulatory - Outpatient Care	1	2	57,600.00		499.50	10,905.96	46,694.04
8. Buddy/Companion Services							
9. Case Management							0.00
10. Child Care Services							
11. Child Welfare Services							
12. Client Advocacy							
13. Day or Respite Care							
14. Drug Reimbursement (Local Program)			19,200.00				19,200.00
15. Early Intervention Services							
16. Food Bank/Nutritional Supplements			960.00			900.00	60.00
17. Health Education/Risk Reduction							
18. Health Insurance							0.00
19. Home Health Care							
20. Hospice Services - Home Based							
21. Hospice Services - Residential Care							
22. Housing Assistance (Not HOPWA)							
23. Legal Services							
24. Mental Health Services			960.00				960.00
25. Nutritional Counseling							
26. Oral Health Care			28,800.00				28,800.00
27. Other Health Care (Specify)							
28. Other Support Services (Specify)							
29. Outreach Services							
30. Permanency Planning							
31. Psychosocial Support Services							
32. Referral							

**DEPARTMENT OF HEALTH
PATIENT CARE NETWORK-GENERAL REVENUE
Monthly Expenditure and Reimbursement Report**



Provider Agency Name and Address:

Health Planning Council of Northeast Florida
644 Cesery Blvd. #210
Jacksonville, FL 32211

From: 02-01-2009 to 02-28-2009

Contract No. CODK1

Preparer's Name: James Allen
Phone Number: (904) 723-2162

ORG: _____

OCA: _____ EO: _____

	Number of Clients Served	Number of Units of Service	Original Amount	Approved Budget	Expenditures This Report	Expenditures Year-To-Date	Contract Balance
Direct Care - Continued:							
33. Rehabilitation Services							
34. Substance Abuse Services - Outpatient			960.00				960.00
35. Substance Abuse Services - Residential							
36. Transportation			595.00				595.00
37. Treatment Adherence Services							
38. Hospital Services							
39. Residential Care (Adult/Child)							
40. Nursing Home Care							
Subtotal Direct Care	1	2	109,075.00	0.00	499.50	11,805.96	97,269.04

C. PROGRAM SUPPORT - STATE PRIORITIES

41. Capacity Building							
42. Case Management Coordination							
43. Developing Standards of Care							
44. Evaluation of Cost Effectiveness							
45. Needs Assessment							
46. Other Program Support - State Priorities (Specify)							
44. Outcome Assessment							
48. Planning and Development							
49. Program Evaluation							
50. Quality Assurance							
51. Technical Assistance							
Subtotal Program Support - State Priorities			0.00	0.00	0.00	0.00	0.00
TOTAL SECTIONS A, B AND C			125,373.00	0.00	1,838.81	22,746.76	102,626.24

D. ADVANCE(S) INFORMATION

Total Advances	_____	Total Contract Amount	125,373.00
Previous Reductions	_____	Expenditures Year -To-Date	22,746.76
Current Reductions	_____	UNPAID Advances	0.00
Remaining Advances	0.00	Balance to Draw	102,626.24
		Total Expenditures This Period	1,838.81
		Less Advances Paid This Period	0.00
		AMOUNT OF FUNDS REQUESTED THIS REPORT	1,838.81
		Type of Request:	
		Regular	X
		Final	_____

I certify that the above report is a true, accurate and correct reflection of the activities of this period; and that the expenditures reported are made only for items which are allowable and directly related to the purpose of this referenced contract.

Signature and Title of Provider Agency Official _____ Date _____ Contract Manager's Signature _____ Date _____

Contract Manager's Supervisor Signature _____ Date _____

Provider Agency Name and Address:

Health Planning Council of Northeast Florida
 644 Cesery Blvd. #210
 Jacksonville, FL 32211

DEPARTMENT OF HEALTH
PATIENT CARE NETWORK-GENERAL REVENUE
 Monthly Expenditure and Reimbursement Report

From: 01-01-2009 to 01-31-2009

Contract No. CODK1



Preparer's Name: James Allen
 Phone Number: (904) 723-2162 ext.106

ORG: _____

OCA: _____ EO: _____

A. ADMINISTRATIVE BUDGET

	Original Amount	Approved Budget	Expenditures This Report	Expenditures Year-To-Date	Contract Balance
1. Salaries					
2. Fringe Benefits					
3. Travel					
4. Office Expenses					
5. Equipment					
6. Other--Audit Fees					
Subtotal Administrative Budget	16,298.00	0.00	1,339.31	9,601.49	6,696.51

B. DIRECT CARE

	Number of Clients Served	Number of Units of Service	Original Amount	Approved Budget	Expenditures This Report	Expenditures Year-To-Date	Contract Balance
7. Ambulatory - Outpatient Care	1	1	57,600.00		20.00	10,406.46	47,193.54
8. Buddy/Companion Services							
9. Case Management							0.00
10. Child Care Services							
11. Child Welfare Services							
12. Client Advocacy							
13. Day or Respite Care							
14. Drug Reimbursement (Local Program)			19,200.00				19,200.00
15. Early Intervention Services							
16. Food Bank/Nutritional Supplements			960.00			900.00	60.00
17. Health Education/Risk Reduction							
18. Health Insurance							0.00
19. Home Health Care							
20. Hospice Services - Home Based							
21. Hospice Services - Residential Care							
22. Housing Assistance (Not HOPWA)							
23. Legal Services							
24. Mental Health Services			960.00				960.00
25. Nutritional Counseling							
26. Oral Health Care			28,800.00				28,800.00
27. Other Health Care (Specify)							
28. Other Support Services (Specify)							
29. Outreach Services							
30. Permanency Planning							
31. Psychosocial Support Services							
32. Referral							

**DEPARTMENT OF HEALTH
PATIENT CARE NETWORK-GENERAL REVENUE
Monthly Expenditure and Reimbursement Report**



Provider Agency Name and Address:

Health Planning Council of Northeast Florida
644 Cesery Blvd. #210
Jacksonville, FL 32211

From: 01-01-2009 to 01-31-2009

Contract No. CODK1

Preparer's Name: James Allen
Phone Number: (904) 723-2162

ORG: _____

OCA: _____ EO: _____

	Number of Clients Served	Number of Units of Service	Original Amount	Approved Budget	Expenditures This Report	Expenditures Year-To-Date	Contract Balance
Direct Care - Continued:							
33. Rehabilitation Services							
34. Substance Abuse Services - Outpatient			960.00				960.00
35. Substance Abuse Services - Residential							
36. Transportation			595.00				595.00
37. Treatment Adherence Services							
38. Hospital Services							
39. Residential Care (Adult/Child)							
40. Nursing Home Care							
Subtotal Direct Care	1	1	109,075.00	0.00	20.00	11,306.46	97,768.54

C. PROGRAM SUPPORT - STATE PRIORITIES

41. Capacity Building							
42. Case Management Coordination							
43. Developing Standards of Care							
44. Evaluation of Cost Effectiveness							
45. Needs Assessment							
46. Other Program Support - State Priorities (Specify)							
44. Outcome Assessment							
48. Planning and Development							
49. Program Evaluation							
50. Quality Assurance							
51. Technical Assistance							
Subtotal Program Support - State Priorities			0.00	0.00	0.00	0.00	0.00
TOTAL SECTIONS A, B AND C			125,373.00	0.00	1,359.31	20,907.95	104,465.05

D. ADVANCE(S) INFORMATION

Total Advances _____	Total Contract Amount _____	125,373.00
Previous Reductions _____	Expenditures Year -To-Date _____	20,907.95
Current Reductions _____	UNPAID Advances _____	0.00
Remaining Advances _____ 0.00	Balance to Draw _____	104,465.05
Total Expenditures This Period _____	1,359.31	Type of Request:
Less Advances Paid This Period _____	0.00	Regular _____ X
AMOUNT OF FUNDS REQUESTED THIS REPORT	1,359.31	Final _____

I certify that the above report is a true, accurate and correct reflection of the activities of this period; and that the expenditures reported are made only for items which are allowable and directly related to the purpose of this referenced contract.

Signature and Title of Provider Agency Official _____ Date _____ Contract Manager's Signature _____ Date _____

Contract Manager's Supervisor Signature _____ Date _____