

**GEORGIA DEPARTMENT OF HUMAN RESOURCES
 GEORGIA DEPARTMENT OF JUVENILE JUSTICE
 ANNUAL COST REPORT - State Fiscal Year 2009
 (Provider's Fiscal Year Ended In 2008)**

REPORTING PERIOD (Exp: **1/01/07 TO 12/31/**) FROM _____ TO _____

AGENCY NAME _____
 AGENCY ADDRESS _____
 AGENCY CITY _____
 AGENCY STATE _____
 ZIP _____
 AGENCY PHONE # (Exp: **4045551212**) _____
 AGENCY FAX # (Exp: **4045552121**) _____
 AGENCY E-MAIL ADDRESS _____

PROGRAM NAME _____
 PROGRAM VENDOR NUMBER _____
 PROGRAM SITE ADDRESS _____
 PROGRAM CITY _____
 PROGRAM STATE _____
 PROGRAM ZIP _____
 PROGRAM PHONE # (Exp: **7775551111**) _____
 PROGRAM FAX # (Exp: **7705552222**) _____
 PROGRAM E-MAIL ADDRESS _____

Program Type
 (X only one)

- CCI
- Maternity
- Second Chance
- Teen Development
- Camp
- CPA
- Specialized Residential (DJJ)
- Other (Specify) _____

Hardware Secure
 (Y or N)

Indicate with X

Program Category
 (X only one)

- Private Non-Profit
- Private For-Profit
- Public

CERTIFICATION OF ACCURACY	
Person Completing Form	Date _____
Signature _____	
Phone # (Exp: 7705553333) _____	
Fax # (Exp: 7705554444) _____	
E-Mail _____	
Authorized Agency Rep	Date _____
Signature _____	
Phone # (Exp: 7705556666) _____	
Fax # (Exp: 7705557777) _____	
E-Mail Address _____	
Certifying Auditor	Date _____
Signature _____	
Phone # (Exp: 7705558888) _____	
Fax # (Exp: 7705559999) _____	
E-Mail Address _____	

UTILIZATION

Program Name: _____
 Program Vendor Number: _____

CAPACITY AND UTILIZATION

Capacity - CCIs Only	Enter
Licensed Capacity of Parent Agency	
Licensed Capacity of this Program	
Maximum Capacity of this Program (if less than licensed capacity)**	0
Number of Months Operational during Reporting Period	0.03

Capacity - CPAs Only	Enter
Average Number of Foster Homes Available During the Year	
Average Number of Foster Home Beds Available During the Year	
Number Of Foster Homes Added During the Year	
Number Of Foster Homes Lost During the Year	
Number of Foster Beds Added During the Year	
Number of Foster Beds Lost During the Year	
Number of Months Operational during Reporting Period	0.03

***Must include e-mail from DFCS RBWO Fiscal Manager reflecting approval 1 - AND to receive new workbook for C.14 !

Instructions To Complete Above
 Licensed capacity of parent agency - the total licensed capacity of the provider agency of which this program is a part
 Licensed capacity of this program - the number of licensed beds in the particular program/site covered by this cost report
 Maximum capacity if less than licensed capacity - will be different than licensed capacity only if some beds were not operational during the report period
 Average monthly operational capacity for **Foster Care** only - the average number of children served monthly by this program

Enter Unduplicated Count of Children Served *By PROGRAM/PLACEMENT*

	CCIs ONLY				CPAs ONLY				TOTAL					
	Base	MWO	2ND Chance	Maternity	Teen Development	Camp	Traditional	Base WO		Max WO	SBWO	SMWVO	SMFWO	PFCM
DFCS (Unduplicated Count of All Children Served)														
MAAC (Multi-Agency Alliance for Children)														
DJJ														
Division of Mental Health														
Other (local governments, other states, private)														
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Enter Number of Days Provided during the cost report period. This is to represent the number of days billed during the cost report time period (bed days, NOT the actual number of days during the fiscal year).

	CCIs ONLY				CPAs ONLY				TOTAL						
	Base	AWO	MWO	2ND Chance	Maternity	Teen Development	Camp	Traditional		Base WO	Max WO	SBWO	SMWVO	SMFWO	PFCM
DFCS (while in normal placement)															
DFCS (while in PRIF, CSP, etc. - excludes home visits, etc.) and either the Primary CPA Foster Parent or the CCI is being paid during treatment placement. Note: do not include in B.50 and in this count (one place only, i.e., do not count the bed days twice)															
MAAC (Multi-Agency Alliance for Children)															
DJJ															
Division of Mental Health															
Other (local governments, other states, private)															
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Instructions For Above Section - One bed filled = 1 day of care provided

Adjusted Utilization @ 80% (bed days for Cost Per Diem Determination) (from worksheet Bases on 899 form)

Program Name _____
 Program Vendor Number _____

PERSONNEL COST DETAIL (Enter WHOLE DOLLARS)

I. Personnel/Costs

A. Direct Child Caring Staff
 (includes house parents) for CCIs
 or Field Case Managers/Case
 Support for the CPAs

Count	Name	Title	Column 1	Column 2	Column 3	Column 4	Reality Check	
			Wages	Benefits	Hours Worked In Program	Computed FTE	Salary Rate Per Hour	Benefits Percentage
1						0.00	#DIV/0!	#DIV/0!
2						0.00	#DIV/0!	#DIV/0!
3						0.00	#DIV/0!	#DIV/0!
4						0.00	#DIV/0!	#DIV/0!
5						0.00	#DIV/0!	#DIV/0!
6						0.00	#DIV/0!	#DIV/0!
248						0.00	#DIV/0!	#DIV/0!
249						0.00	#DIV/0!	#DIV/0!
250						0.00	#DIV/0!	#DIV/0!
I. A. Total Program Direct Care Staff			\$0	\$0	0.00	0.00		
B. Human Services Professional (HSP) Staff -- Residential Providers Only ! -- CCIs " OR " Field Staff Supervisory Staff -- Foster Providers Only ! -- CPAs								
Count	Name	Title	Wages	Benefits	Hours Worked	Computed FTE	Salary Rate Per Hour	Benefits Percentage
1						0.00	#DIV/0!	#DIV/0!
2						0.00	#DIV/0!	#DIV/0!
3						0.00	#DIV/0!	#DIV/0!
4						0.00	#DIV/0!	#DIV/0!
5						0.00	#DIV/0!	#DIV/0!
9						0.00	#DIV/0!	#DIV/0!
10						0.00	#DIV/0!	#DIV/0!
I. B. Total Program HSP/Field Supv Salaries			\$0	\$0	0.00	0.00		

Program Name _____
 Program Vendor Number _____

PERSONNEL COST DETAIL (Enter WHOLE DOLLARS)

I. Personnel/Costs

Count	Name	Title	Column 1	Column 2	Column 3	Column 4	Reality Check		
			Wages	Benefits	Hours Worked	Computed	Salary Rate	Per Hour	Percentage
1						0.00		#DIV/0!	#DIV/0!
2						0.00		#DIV/0!	#DIV/0!
3						0.00		#DIV/0!	#DIV/0!
4						0.00		#DIV/0!	#DIV/0!
5						0.00		#DIV/0!	#DIV/0!
6						0.00		#DIV/0!	#DIV/0!
7						0.00		#DIV/0!	#DIV/0!
15						0.00		#DIV/0!	#DIV/0!
			\$0	\$0	0.00	0.00			

I. C. Total Training & Recruitment Salaries

Count	Name	Title	Column 1	Column 2	Column 3	Column 4	Reality Check		
			Wages	Benefits	Hours Worked	Computed	Salary Rate	Per Hour	Percentage
1						0.00		#DIV/0!	#DIV/0!
2						0.00		#DIV/0!	#DIV/0!
3						0.00		#DIV/0!	#DIV/0!
10						0.00		#DIV/0!	#DIV/0!
			\$0	\$0	0.00	0.00			

I. D. Total Program Food & Beverage Salaries

Count	Name	Title	Column 1	Column 2	Column 3	Column 4	Reality Check		
			Wages	Benefits	Hours Worked	Computed	Salary Rate	Per Hour	Percentage
1						0.00		#DIV/0!	#DIV/0!
2						0.00		#DIV/0!	#DIV/0!
3						0.00		#DIV/0!	#DIV/0!
10						0.00		#DIV/0!	#DIV/0!
			\$0	\$0	0.00	0.00			

E. Nursing Staff (non-Medicicaid Billable)

Count	Name	Title	Column 1	Column 2	Column 3	Column 4	Reality Check		
			Wages	Benefits	Hours Worked	Computed	Salary Rate	Per Hour	Percentage
1						0.00		#DIV/0!	#DIV/0!
2						0.00		#DIV/0!	#DIV/0!
3						0.00		#DIV/0!	#DIV/0!
10						0.00		#DIV/0!	#DIV/0!
			\$0	\$0	0.00	0.00			

Program Name _____
 Program Vendor Number _____

PERSONNEL COST DETAIL (Enter WHOLE DOLLARS)

I. Personnel/Costs

Realty Check
 Column 5 Column 6

	Column 1	Column 2	Column 3	Column 4
I. E. Total Program Nursing Salaries	\$0	\$0	0.00	0.00
F. ALL Other Administrative / And ALL Other SupportStaff				
Count	Name	Title	Annual Wages	Annual Benefits
1				
2				
3				
24				
25				
			Program %	Program Cost
			100	\$0
			5	\$0
			1	\$0
			1	\$0
				\$0
I. F. Total Admin Salaries	\$0	\$0		\$0
Total Personnel	\$0			

	Benefits Percentage
Direct Care	#DIV/0!
HSP / SUPV	#DIV/0!
Training & Recruitment	#DIV/0!
Food & Beverage	#DIV/0!
Nursing	#DIV/0!
Administrative	#DIV/0!
Total	#DIV/0!

Program Name:

0

Program Vendor Number

0

III. PROGRAM COST DETAIL

A. Consumable Supplies and Miscellaneous Expenses	Column 1 Annual Cost	Column 2 Direct Program Amount	Column 3 Allocated Amount	Column 4 Allocation Basis
A. Office Supplies	\$0			
B. Postage	\$0			
C. Printing	\$0			
D. Telephone	\$0			
E. Program, Vocational, and Craft Supplies	\$0		XXXXXX	XXXXXX
F. Health and First Aid Supplies	\$0		XXXXXX	XXXXXX
G. Food & Beverage	\$0			
H. Household & Janitorial Supplies	\$0			
I. Children's Allowances/Gifts	\$0		XXXXXX	XXXXXX
J. Children's Clothing	\$0		XXXXXX	XXXXXX
K. Children's Incidentals	\$0		XXXXXX	XXXXXX
L. Activities / Outings For Children	\$0		XXXXXX	XXXXXX
M. Children's School Supplies	\$0		XXXXXX	XXXXXX
N. Children's After-School	\$0		XXXXXX	XXXXXX
O. Professional Dues, Subscriptions, etc.	\$0			
P. Liability Insurance	\$0			
Q. Training/Conference Costs	\$0			
R. Other (specify) >>>>	\$0			
S. Other (specify) >>>>	\$0			
T. Other (specify) >>>>	\$0			

III. A. Total Consumable \$0 \$0 \$0

III B. Indirect Agency Costs * \$0

* Indirect Agency Costs From Attachment A
MAY NOT EXCEED 15% OF TOTAL Allowable EXPENSES
Calculated Percentage #DIV/0!

Program Name:

0

Program Vendor Number

0

PROGRAM COST DETAIL

<u>COST ITEM</u>	<u>ANNUAL COST</u>	Column 2	Column 3	Column 4
		Direct Program	Allocated	Allocation
		Amount	Amount	Basis
1. Allowable Occupancy Cost Detail				
				% sq foot
A. Mortgage Interest	\$0			% sq foot
B. Rent/Lease	\$0			% sq foot
C. Building Insurance	\$0			% sq foot
D. Utilities	\$0			% sq foot
E. Property Tax	\$0			% sq foot
F. Maintenance & Repair	\$0			% sq foot
G. Other (Must Specify): >>>	\$0			% sq foot
Total Occupancy Cost	\$0	\$0	\$0	
2. Travel Cost Detail				
A. Purchased Transportation For Client	\$0		XXXX	XXXX
B. Agency Vehicle Operating Cost	\$0			
C. Agency Vehicle Insurance	\$0			
D. Staff Mileage Reimbursement - NON Training Related (see Consumables Line Item "Q")	\$0			
E. Transportation Rental	\$0			
F. Other (Must Specify) >>	\$0			
Total Travel Cost	\$0	\$0	\$0	
Miles Reimbursed for 24.D. Staff Mileage				
Reimbursement Per Mile				#DIV/0!
3. Equipment Cost Detail				
A. Vehicle/Equip. Loan Interest	\$0			
B. Rental & Maintenance of Equipment (Not Vehicle)	\$0			
C. Vehicle Lease	\$0			
D. Depreciated Equipment	\$0			
Total Equipment Cost	\$0	\$0	\$0	

Program Name:
Program Vendor Number

0
_____0

COST REPORT AND AUDIT RECONCILIATION

Program Cost Totals	Cost Report
Personnel (pg 2)	\$0
Contracts (pg 3)	\$0
Consumables (pg 4)	\$0
Indirect (pg 4)	\$0
Occupancy (pg 5)	\$0
Travel (pg 5)	\$0
Equipment (pg 5)	\$0
Total Program Cost per Cost Report	\$0
Less revenue offsets	\$0
Unadjusted Per Diem Cost*	#DIV/0!
Adjusted Per Diem Cost**	#DIV/0!
<i>If B22 = Error, Total Program Cost per audit is less than reported. Correct The Cost Report Before Submitting !</i>	OKAY
Program Cost per Audit -ENTER	
Variance	\$0

Revenue Totals	Cost Report
USDA	\$0
Other Federal	\$0
DFCS Per Diem (while In Residence)	\$0
DFCS Per Diem (while in Respite)	\$0
DFCS Per Diem (while in PRTF, CSP, etc. - excludes home visits, etc.)	\$0
DFCS reimbursements non-perdiem	\$0
MAAC (Multi- Agency Alliance for Children)	\$0
DJJ Per Diem	\$0
Division of Mental Health	\$0
Other (local governments, other states, private)	\$0
Private	\$0
Total Program Revenue per Cost Rpt.	\$0
Must explain revenue variance if +/- 5% of total program cost. Submit separate document with explanation along with Cost	#DIV/0!
Program Revenues per Audit - ENTER	
Variance	\$0

* Note: Child Caring per diem costs subject to utilization adjustment to 80% of licensed capacity; not reflected in this calculation

Adjustment Based on Minimum Utilization Factor of 80% (Applicable to CCIs Only**)

Please explain any variances (other than those due to rounding). Attach additional pages/worksheets if necessary.

Variance Total \$0

1) Bad Debt	
2) Contingencies	
3) Contributions/Donations	
4) Entertainment	
5) Building Depreciation	
6) Fines/Penalties	
7) Fund Raising	
8) Investments	
9) Prohibited Activities	
10) Organizational Costs	
11) Lobbist Support	
12) Other - Must Explain	
13) Other - Must Explain	
UnExplained Variance	\$0

\$0

1) Interest Income	
2) Revenue In Kind	
3) UnReported Grants	
4) Endowments	
12) Other - Must Explain	
13) Other - Must Explain	
UnExplained Variance	\$0

Program Name:

0

Program Vendor Number

0

Attachment A

Detail of Indirect Agency Costs

Allowable Costs Description	Total Allocated Cost	Allocation Basis*
Salary		
Benefits		
Occupancy		
Travel		
Training		
Liability Insurance		
Consummable Supply		
TOTAL INDIRECT AGENCY COST	\$0	

* for example %this program of total direct costs for agency: MTDC applied to allowable administrative costs

MAY NOT EXCEED 15% OF TOTAL EXPENSE

As Computed

#DIV/0!

