

NYS Department of Health  
Bureau of Child and Adolescent Health  
ESP Corning Tower  
Room 227  
Albany, NY United States 12237-0618

**NEW YORK STATE DEPARTMENT OF HEALTH  
BUDGET STATEMENT AND REPORT OF EXPENDITURES**

CONTRACT PERIOD : 01-JUL-09 - 31-DEC-09  
 CONTRACT # : C018578  
 REPORT for the PERIOD : 01-JUL-09 - 30-SEP-09  
 RF ACCOUNT NO : 52187  
 VOUCHER NO : 1

| BUDGET ITEM                  | BUDGETED AMOUNT  | COLUMN I<br>EXPENDITURES<br>PRIOR PERIODS | COLUMN II<br>EXPENDITURES<br>CURRENT PERIOD | COLUMN III<br>TOTAL EXPENDED<br>TO DATE |
|------------------------------|------------------|---|---|---|
| <b>PERSONNEL</b>             |                  |   |   |   |
| Salaries and Wages           | 18,881.00        | 0.00                                      | 6,011.21                                    | 6,011.21                                |
| <b>FRINGE BENEFITS</b>       | 7,418.00         | 0.00                                      | 2,254.20                                    | 2,254.20                                |
| <b>NON-PERSONAL SERVICES</b> |                  |   |   |   |
| Supplies                     | 92.00            | 0.00                                      | 0.00  | 0.00                                    |
| Equipment                    | 0.00             | 0.00                                      | 0.00  | 0.00                                    |
| Travel                       | 0.00             | 0.00                                      | 0.00  | 0.00                                    |
| Consultant Costs             | 9,375.00         | 0.00                                      | 0.00  | 0.00                                    |
| Other Expenses               | 880.00           | 0.00                                      | 0.00  | 0.00                                    |
| Subawards                    | 0.00             | 0.00                                      | 0.00  | 0.00                                    |
| Undistributed Budget         | 0.00             | 0.00                                      | 0.00  | 0.00                                    |
| <b>ADMINISTRATIVE COSTS</b>  | 0.00             | 0.00                                      | 0.00  | 0.00                                    |
| <b>SUBTOTALS</b>             |                  |   |   |   |
| <b>NON-PERSONAL SVCS</b>     | 10,347.00        | 0.00                                      | 0.00  | 0.00                                    |
| <b>PERSONAL SERVICES</b>     | 26,299.00        | 0.00                                      | 8,265.41                                    | 8,265.41                                |
| <b>GRAND TOTAL</b>           | <b>36,646.00</b> | <b>0.00</b>                               | <b>8,265.41</b>                             | <b>8,265.41</b>                         |

# STANDARD VOUCHER

STATE OF  
NEW YORK

|   |
|---|
| Voucher No.<br><div style="text-align: center;">1</div> |
|---|

|   |                   |                         |                                |
|---|-------------------|-------------------------|--------------------------------|
| 1 Originating Agency<br><b>NYS Department of Health</b> | Orig. Agency Code | Interest Eligible (Y/N) | 2 P-Contract<br><b>C018578</b> |
|---|-------------------|-------------------------|--------------------------------|

|                              |              |                                |
|------------------------------|--------------|--------------------------------|
| Payment Date (MON) (DD) (YY) | OSC Use Only | Liability Date (MON) (DD) (YY) |
|------------------------------|--------------|--------------------------------|

|                                 |            |                               |       |              |                          |
|---------------------------------|------------|-------------------------------|-------|--------------|--------------------------|
| 3 Payee ID<br><b>14-1368361</b> | Additional | Zip Code<br><b>12201-0009</b> | Route | Payee Amount | MIR Date (MON) (DD) (YY) |
|---------------------------------|------------|-------------------------------|-------|--------------|--------------------------|

|  |          |            |
|--|----------|------------|
| 4 Payee Name (Limit to 30 Spaces)<br><b>THE RESEARCH FOUNDATION OF</b> | IRS Code | IRS Amount |
|--|----------|------------|

|  |            |           |                 |                     |
|--|------------|-----------|-----------------|---------------------|
| Payee Name (Limit to 30 Spaces)<br><b>STATE UNIVERSITY OF NEW YORK</b> | Stat. Type | Statistic | Indicator-Dept. | Indicator-Statewide |
|--|------------|-----------|-----------------|---------------------|

|   |   |
|---|---|
| Address (Limit to 30 Spaces)<br><b>PO Box 9</b> | 5 Ref/Inv. No. (Limit to 20 Spaces)<br><b>52187 /</b> |
|---|---|

|  |   |
|--|---|
| Address (Limit to 30 Spaces)<br><b>ATTN: CASH RECEIPT DEPARTMENT</b> | Ref/Inv. Date (MON) (DD) (YY)<br><b>SEP / 30 / 09</b> |
|--|---|

|   |                    |                               |
|---|--------------------|-------------------------------|
| City Spaces (Limit to 20 Spaces)<br><b>ALBANY</b> | State<br><b>NY</b> | Zip Code<br><b>12201-0009</b> |
|---|--------------------|-------------------------------|

| 6 Purchase Order No. and Date | Description of Material/Service<br><small>If items are too numerous to be incorporated into the block below, use Form AC 93 and carry total forward.</small> | Quantity | Unit | Price | Amount            |
|-------------------------------|--|----------|------|-------|-------------------|
|                               | <b>REQUESTED REIMBURSEMENT FOR THE PERIOD:<br/>01-JUL-09 - 30-SEP-09</b>   |          |      |       | <b>\$8,265.41</b> |

|  |            |                   |
|--|------------|-------------------|
| 7 Payee Certification:<br><small>I certify that the above bill is just, true and correct; that no part thereof has been paid except as state and that the balance is actually due and owing, and that taxes from which the State is exempt are excluded.</small>                                     | Total      | <b>\$8,265.41</b> |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p style="text-align: center;"><b>Michele Ehrenreich</b><br/>Sr. Fiscal Specialist</p> <p>_____<br/>Payee's Signature in Ink</p> </div> <div style="width: 35%;"> <p>_____<br/>Name / Title</p> </div> </div> | Discount % |                   |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 20%;"> <p><b>30-SEP-09</b><br/>Date</p> </div> <div style="width: 60%;"> <p style="text-align: center;"><b>THE RESEARCH FOUNDATION OF SUNY</b><br/>Name Of Company</p> </div> </div>                                 | Net        | <b>\$8,265.41</b> |

**FOR AGENCY USE ONLY**

**STATE COMPTROLLER'S PRE-AUDIT**

|                      |   |                                |   |
|----------------------|---|--------------------------------|---|
| Merchandise Received | I certify that this voucher is correct and just, and payment is approved, and the goods or services rendered or furnished are for use in the performance of the official functions and duties of this agency. | Verified                       | Certified For Payment of Net Amount<br><br>By _____ |
| Date                 | Authorized Signature  | Audited                        |   |
| Page No.             |   | Special Approval (as Required) |   |
| By                   | Date Title  |                                |   |

**Expenditure**

**Liquidation**

| Cost Center Code |                  |     |    | Object | Accum |           | Amount | Orig. Agency | PO/Contract | Line | F/P |
|------------------|------------------|-----|----|--------|-------|-----------|--------|--------------|-------------|------|-----|
| Dept.            | Cost Center Unit | Var | Yr |        | Dept. | Statewide |        |              |             |      |     |
|                  |                  |     |    |        |       |           |        |              |             |      |     |
|                  |                  |     |    |        |       |           |        |              |             |      |     |
|                  |                  |     |    |        |       |           |        |              |             |      |     |

**OSC**

Check if Continuation form is attached.