# NEW YORK STATE

**CONSOLIDATED FISCAL REPORT**

***For the Period: July 1, 2008 to June 30, 2009***

**SCHEDULE CFR-i**
**AGENCY IDENTIFICATION AND CERTIFICATION STATEMENT**



**AGENCY NAME:** _____

**AGENCY ADDRESS:** _____

_____

☐ Please check the box if the agency address changed from the prior reporting period.

**AGENCY CODE:** _____

**COUNTY NAME:** _____

**COUNTY CODE:** _____

**TYPE OF OWNERSHIP:**

**NOT-FOR-PROFIT:** ☐

**PROPRIETARY:** ☐

**GOVERNMENTAL:** ☐

**SCHOOL CODE (SED ONLY):** __ __ __ __ __ __ __ __ __ __ __ __

**Person to Contact with Regard to Questions Concerning this Report:**

**FEDERAL EMPLOYER ID NUMBER:** _____

_____ ( ) _____

**Name** **Telephone Number**

_____

**Title**

**CHECK THE STATE AGENCY(IES):**

☐ OMH
☐ OMRDD
☐ OASAS
☐ SED

**CHECK THE CFR SUBMISSION TYPE:**

☐ FULL CFR
☐ ABBREVIATED CFR
☐ ARTICLE 28 ABBREVIATED CFR
☐ MINI-ABBREVIATED CFR
☐ ESTIMATED CLAIM

_____ ( ) _____

**E-mail Address** **FAX Number**

☐ Please check the box if the person to contact changed from the prior reporting period.

**MISREPRESENTATION OF ANY INFORMATION CONTAINED IN THIS REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER NEW YORK STATE LAW.**

**CERTIFICATION STATEMENT**

**I HEREBY CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT, THAT THE INFORMATION FURNISHED IN THIS REPORT HAS BEEN COMPLETED IN ITS ENTIRETY, AND IS IN ACCORDANCE WITH THE INSTRUCTIONS AND IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER ATTEST TO THE FACT THAT THERE ARE RECORDS AND ALLOCATION WORKSHEETS TO SUPPORT ALL THE INFORMATION CONTAINED HEREIN, IN THE CUSTODY OF THE ABOVE NAMED SPONSORING AGENCY. I ACKNOWLEDGE THAT THE DEPARTMENT OF MENTAL HYGIENE, OR ANY OF ITS OFFICES OR DIVISIONS, OR THE STATE EDUCATION DEPARTMENT, OR ANY OF ITS OFFICES OR DIVISIONS, MAY REJECT THIS REPORT IF IT HAS NOT BEEN FULLY, OR ACCURATELY COMPLETED.**

_____

**Date**

**Name and Title**

( ) _____

**Telephone Number**

**E-mail Address**

**Signature of Chief Executive Officer**

☐ Please check the box if the Chief Executive Officer changed from the prior reporting period.

# NEW YORK STATE

**CONSOLIDATED FISCAL REPORT**

***For the Period: July 1, 2008 to June 30, 2009***

**SCHEDULE CFR-ii**
**INDEPENDENT ACCOUNTANT'S REPORT**
**VOLUNTARY AGENCY or**
**COUNTY GOVERNMENT**



**AGENCY NAME:** _____ **AGENCY CODE:** _____ **SCHOOL CODE (SED ONLY):** __ __ __ __ __ __ __ __ __ __ __ __

We have audited the accompanying balance sheet of the Agency/County as of June 30, 2009 and the accompanying related statements of operations, changes in net assets or equity, and cash flows for the year then ended. These financial statements are the responsibility of the Agency's/County's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe our audit provides a reasonable basis for our opinion.

In our opinion, the aforementioned financial statements present fairly, in all material respects, the financial position of the Agency/County as of June 30, 2009 and the results of its operations, changes in net assets or equity and its cash flows, for the year then ended, in conformity with accounting principles generally accepted in the United States of America.

Our audit was made for the purpose of forming an opinion on the basic financial statements taken as a whole. The information included on Schedules (as applicable) CFR-1, lines 13, 16, 17, 20, 41, 48, 63-67, 69-107; CFR-2; CFR-3; CFR-4; CFR-4A; CFR-5; DMH-1; OMRDD-3; OMRDD-4; OMH-1; and SED-1, which is the responsibility the Agency's/County's management, is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such accompanying information reported on the CFR with Document Control Number _____ has been subjected to the auditing procedures applied in the audit of the basic financial statements and, in our opinion, are stated fairly in all material respects when considered in relation to the basic financial statements taken as a whole.

The other information included in this Consolidated Fiscal Report identified by Document Control Number _____, not detailed in the preceding paragraph, was not audited by us and, accordingly, we express no opinion thereon.

We have examined the above detailed schedules' conformity with the applicable instructions relating to the preparation of those schedules contained within the Consolidated Fiscal Reporting and Claiming Manual for the year ended June 30, 2009. The Agency's/County's management is responsible for the schedules' conformity with those instructions. Our responsibility is to express an opinion on the schedules' conformity with those instructions based upon our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence supporting the above referenced CFR schedules' conformity with the applicable instructions and performing such other procedures as we considered necessary in the circumstances including following the procedures contained in Appendix AA of the Consolidated Fiscal Report and Claiming Manual. We believe our examination provides a reasonable basis for our opinion.

In our opinion, the schedules detailed above are, in all material respects, in conformity with the applicable instructions relating to the preparation of the Consolidated Fiscal Report as furnished by the New York State Office of Mental Retardation and Developmental Disabilities, New York State Office of Mental Health, New York State Office of Alcoholism and Substance Abuse, and New York State Education Department for the year ended June 30, 2009 .

This report is intended solely for the information and use of management of the Agency/County, the New York State governmental funding agencies, and any funding Counties that are required to receive a copy of this report and is not intended to be and should not be used by anyone other than these specified parties.

**The undersigned hereby certifies this opinion and that we have disclosed any and all material facts known to us, disclosure of which is necessary to make this opinion, the basic financial statements and the above referenced CFR schedules not misleading. The undersigned hereby further certifies that we will disclose any material fact discovered by us subsequent to this certification, which existed at the time of this certification and was not disclosed in the basic financial statements or the above referenced CFR schedules, the disclosure of which is necessary to make the basic financial statements or the CFR schedules not misleading and will disclose any material misstatement in said financial statements or the above referenced CFR schedules.**

**During the period of this professional engagement, at the time of expressing this opinion and during the period covered by the financial statements, we did not have nor were committed to acquire, any direct financial interest or material indirect financial interest in the ownership or operation of the facility and we were not connected in any way with the ownership, financing or operation of the facility as a director, officer or employee, or in any capacity other than as an independent certified public accountant or independent public accountant.**

| Date CFR-ii Signed | Signature of Independent Accountant, Firm, or Sole Practitioner | CPA Firm Registration Number |
|---|---|---|
| *Date of Report (Enter the date of the audit report on the financial statements.) | Firm Name | |
| | Firm Address | |
| Telephone Number | Firm Contact Person | |

* The Auditor has not performed any audit procedures since the date of the Auditor's Report on the financial statements.

# NEW YORK STATE

**CONSOLIDATED FISCAL REPORT**

***For the Period: July 1, 2008 to June 30, 2009***

**SCHEDULE CFR-iiA**
**INDEPENDENT ACCOUNTANT'S REPORT**
**VOLUNTARY AGENCY or**
**COUNTY GOVERNMENT**



**AGENCY NAME:** _____ **AGENCY CODE:** _____ **SCHOOL CODE (SED ONLY):** __ __ __ __ __ __ __ __ __ __ __ __

We have examined the following schedules' conformity with the applicable instructions relating to the preparation of those schedules contained within the Consolidated Fiscal Reporting and Claiming Manual of the agency listed above for the year ended June 30, 2009: Schedules (as applicable) CFR-1, lines 13, 16, 17, 20, 41, 48, 63-67, 69-107; CFR-2; CFR-3; CFR-4; CFR-4A; CFR-5; DMH-1; OMRDD-3; OMRDD-4; OMH-1; and SED-1 as reported on the CFR with Document Control Number_____ . Management is responsible for the schedules' conformity with those instructions. Our responsibility is to express an opinion on the schedules' conformity with those instructions based upon our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence supporting the above referenced CFR schedules' conformity with the applicable instructions and performing such other procedures as we considered necessary in the circumstances including following the procedures contained in Appendix AA of the Consolidated Fiscal Report and Claiming Manual for the year ended June 30, 2009. We believe our examination provides a reasonable basis for our opinion.

In our opinion, the above referenced schedules are, in all material respects, in conformity with the applicable instructions relating to the preparation of the Consolidated Fiscal Report as furnished by the New York State Office of Mental Retardation and Developmental Disabilities, New York State Office of Mental Health, New York State Office of Alcoholism and Substance Abuse, and New York State Education Department for the year ended June 30, 2009.

This report is intended solely for the information and use of management of the Agency/County, the New York State governmental funding agencies, and any funding Counties that are required to receive a copy of this report and is not intended to be and should not be used by anyone other than these specified parties.

The undersigned hereby certifies this opinion and that we have disclosed any and all material facts known to us, disclosure of which is necessary to make this opinion and the above referenced CFR schedules not misleading. The undersigned hereby further certifies that we will disclose any material fact discovered by us subsequent to this certification , which existed at the time of this certification and was not disclosed the in the above referenced CFR schedules, the disclosure of which is necessary to make the above referenced CFR schedules not misleading and will disclose any material misstatement in said CFR schedules.

During the period of this professional engagement and at the time of expressing this opinion, we did not have nor were committed to acquire, any direct financial interest or material indirect financial interest in the ownership or operation of the facility and we were not connected in any way with the ownership, financing or operation of the facility as a director, officer or employee, or in any capacity other than as an independent certified public accountant or independent public accountant.

**Date of Examination Report**

**Signature of Independent Accountant, Firm, or Sole Practitioner**

**CPA Firm Registration Number**

**Firm Name**

**Telephone Number**

**Firm Address**

**Firm Contact Person**

**COMPLETE ONLY IF THIS REPORT CONTAINS STATE AID FUNDED PROGRAMS**

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
***For the Period: July 1, 2008 to June 30, 2009***

**SCHEDULE CFR-iii COUNTY/NYC CERTIFICATION STATEMENT**

**AGENCY NAME:** _____ **AGENCY CODE:** _____



**COUNTY/NYC - OPERATED OR VOLUNTARY LOCAL SERVICE PROVIDER CERTIFICATION**

**I certify that the attached statement fully and accurately represents all reportable income and expenditures made for services performed in accordance with the provision of the Mental Hygiene Law and approved budgets.**

**There are records and worksheets to support this statement in the custody of the above named agency. Such records and worksheets include the necessary summaries of payrolls and time records, abstracts from ledgers, registers or other expense records. All income from fees, all payments by other State or Federal agencies and any other income have been recorded, included and summarized in support of the amounts reported herein.**

**Records and worksheets, including records which show that the agency has applied for and received, or received formal notification of refusal of, all forms of third party reimbursement and federal aid, which may be appropriate for such services, are on file at the above location and available for audit by the Office of the State Comptroller and/or representatives of the New York State Commissioner of the Office of Alcoholism and Substance Abuse Services, Commissioner of the Office of Mental Retardation and Developmental Disabilities, or the Commissioner of the Office of Mental Health.**

**I understand that the State Aid paid on the basis of this certification for local assistance providers may be adjusted, modified and reduced if the records referred to above do not support this financial statement, and that such a reduction may require a repayment to the State of any overpayments which are disclosed by audit.**

**Signed:** _____
**(For Voluntary Local Service Provider)**

**Title:** _____
**(Service Provider's Chief Executive Officer)**

**Date:** _____

**Signed:** _____
**(For County/City Operated Local Service Provider)**

**Title:** _____
**(LGU's Chief Fiscal Officer)**

**Date:** _____

**LOCAL GOVERNMENTAL UNIT CERTIFICATION**

**I have verified that the costs and revenue reported in the Total column of Schedule DMH-3 are consistent with the contract expenditures and income amounts as approved by this local governmental unit. I also affirm that the expenditures were necessary to provide the services covered by the approved budget and that further review will establish if all income has been fully reported.**

**I understand that the State Aid paid to this local governmental unit on the basis of this certification may be adjusted, modified and reduced if records are not available, or do not support this financial statement. I hereby recommend that final reimbursement be approved.**

**Signed:** _____
**Director of Community Mental Health Services**

**Local Governmental Unit:** _____
**Specify**

**Date:** _____

Funding State Agency:
- ☐ OMH ☐ SED
- ☐ OMRDD
- ☐ OASAS

# NEW YORK STATE
**CONSOLIDATED FISCAL REPORT**
***For the Period: July 1, 2008 to June 30, 2009***

**SCHEDULE CFR-1**
**PROGRAM/SITE DATA**



**AGENCY NAME:**_____
**AGENCY CODE:**_____
**SCHOOL CODE: (SED ONLY)** __ __ __ __ __ __ __ __ __ __ __ __

| Line No. | COLUMN NUMBER / ITEM DESCRIPTION | Cost Codes | | | | | |
|---|---|---|---|---|---|---|---|
| **SECTION A: GENERAL INFORMATION** | | | | | | | |
| **1** | Program Type | **00070** | | | | | |
| **2** | Program Code (Program Code Index) | **00010** | ( ) | ( ) | ( ) | ( ) | ( ) |
| **3** | Program/Site Identification Number | **00050** | | | | | |
| **4** | Program/Site Name | **00020** | | | | | |
| **5** | Program/Site Address (Line One) | **00030** | | | | | |
| **6** | Program/Site Address (Line Two) | **00040** | | | | | |
| **7** | Medicaid Provider Agreement Number (DMH only) | **00060** | | | | | |
| **8** | County Code (See Appendix C) | **00080** | | | | | |
| **9** | Date Site Opened | **00090** | | | | | |
| **10** | Certified Capacity (OASAS, OMRDD and SED only) | **00100** | | | | | |
| **11** | Actual Capacity (OMH, OMRDD and SED only) | **00110** | | | | | |
| **12** | Actual Days Program/Site Open | **00160** | | | | | |
| **13** | Units of Service | **00120** | | | | | |
| **14** | Respite or TUBS Units of Service (OMRDD only) | **00130** | | | | | |
| **15** | Program/Site Square Footage (OASAS, OMRDD and SED Only) | **00150** | | | | | |

Funding State Agency:
☐ OMH ☐ SED
☐ OMRDD
☐ OASAS

# NEW YORK STATE
**CONSOLIDATED FISCAL REPORT**
***For the Period: July 1, 2008 to June 30, 2009***

**SCHEDULE CFR-1**
**PROGRAM/SITE DATA**



**AGENCY NAME:**_____
**AGENCY CODE:**_____
**SCHOOL CODE: (SED ONLY)** __ __ __ __ __ __ __ __ __ __ __ __

| Line No. | COLUMN NUMBER / ITEM DESCRIPTION | Cost Codes | | | | | |
|---|---|---|---|---|---|---|---|
| | **Program Code (Program Code Index)** | 00010 | ( ) | ( ) | ( ) | ( ) | ( ) |
| | **Program/Site Identification Number** | 00050 | | | | | |
| **SECTION B: EXPENSES** | | | | | | | |
| | **PERSONAL SERVICES** | | | | | | |
| 16 | Personal Services - Program/Site & Program Admin | 11999 | | | | | |
| 17 | Vacation Accruals - Program/Site & Program Admin | 12999 | | | | | |
| | **FRINGE BENEFITS** | | | | | | |
| 18 | Mandated Fringe Benefits | 13200 | | | | | |
| 19 | Non-Mandated Fringe Benefits | 13300 | | | | | |
| 20 | Total Fringe Benefits (Sum Lines 18 & 19) | 13999 | | | | | |
| | **OTHER THAN PERSONAL SERVICES (OTPS)** | | | | | | |
| 21 | Food | 14010 | | | | | |
| 22 | Repairs and Maintenance | 14020 | | | | | |
| 23 | Utilities | 14030 | | | | | |
| 24 | Transportation Related-Participant | 14040 | | | | | |
| 25 | Staff Travel | 14250 | | | | | |
| 26 | Participant Incidentals | 14050 | | | | | |
| 27 | Expensed Adaptive Equipment (OMRDD and SED only) | 14070 | | | | | |
| 28 | Expensed Equipment | 14080 | | | | | |
| 29 | Sub-Contract Raw Materials | 14090 | | | | | |
| 30 | Participant Wages-Non-Contract | 14100 | | | | | |

Funding State Agency:
☐ OMH ☐ SED
☐ OMRDD
☐ OASAS

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
*For the Period: July 1, 2008 to June 30, 2009*

**SCHEDULE CFR-1**
**PROGRAM/SITE DATA**



**AGENCY NAME:**_____
**AGENCY CODE:**_____
**SCHOOL CODE: (SED ONLY)** __ __ __ __ __ __ __ __ __ __ __ __

| Line No. | COLUMN NUMBER / ITEM DESCRIPTION | Cost Codes | | | | | |
|---|---|---|---|---|---|---|---|
| | **Program Code (Program Code Index)** | **00010** | ( ) | ( ) | ( ) | ( ) | ( ) |
| | **Program/Site Identification Number** | **00050** | | | | | |
| **31** | Participant Wages-Contract | **14110** | | | | | |
| **32** | Participant Fringe Benefits | **14120** | | | | | |
| **33** | Section 43.04 Services Assessment (OMRDD only) | **14130** | | | | | |
| **34** | Staff Development | **14140** | | | | | |
| **35** | Contracted Direct Care and Clinical Personal Svs. (from CFR-4A) | **14150** | | | | | |
| **36** | Supplies and Materials - Non-Household | **14160** | | | | | |
| **37** | Household Supplies | **14170** | | | | | |
| **38** | Telephone | **14190** | | | | | |
| **39** | Insurance - General | **14260** | | | | | |
| **40** | Other (Detail Required) | **14998** | | | | | |
| **41** | Total Other Than Personal Services (Sum Lines 21-40) | **14999** | | | | | |
| | **EQUIPMENT-PROVIDER PAID** | | | | | | |
| **42** | Lease/Rental Vehicle | **15010** | | | | | |
| **43** | Lease/Rental Equipment | **15020** | | | | | |
| **44** | Depreciation-Vehicle | **15040** | | | | | |
| **45** | Depreciation-Equipment | **15050** | | | | | |
| **46** | Interest-Vehicle | **15070** | | | | | |
| **47** | Other (Detail Required) | **15998** | | | | | |
| **48** | Total Equipment (Sum of Lines 42-47) | **15999** | | | | | |
| | **PROPERTY-PROVIDER PAID** | | | | | | |
| **49** | Lease/Rental-Real Property | **16010** | | | | | |
| **50** | Leasehold/Leasehold Improvements | **16020** | | | | | |
| **51** | Depreciation-Building | **16030** | | | | | |
| **52** | Depreciation Building/Land Improvements | **16040** | | | | | |

Funding State Agency:
☐ OMH ☐ SED
☐ OMRDD
☐ OASAS

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
*For the Period: July 1, 2008 to June 30, 2009*

**SCHEDULE CFR-1**
**PROGRAM/SITE**
**DATA**



**AGENCY NAME:**_____

**AGENCY CODE:**_____

**SCHOOL CODE: (SED ONLY)** __ __ __ __ __ __ __ __ __ __ __ __

| Line No. | COLUMN NUMBER / ITEM DESCRIPTION | Cost Codes | | | | | |
|---|---|---|---|---|---|---|---|
| | **Program Code (Program Code Index)** | 00010 | ( ) | ( ) | ( ) | ( ) | ( ) |
| | **Program/Site Identification Number** | 00050 | | | | | |
| 53 | Mortgage/Capital Improvements Interest (Report MCFFA/DASNY Bond Int. on Line 59) | 16060 | | | | | |
| 54 | Mortgage Expenses | 16070 | | | | | |
| 55 | Insurance-Property & Casualty | 16080 | | | | | |
| 56 | Real Estate Taxes | 16090 | | | | | |
| 57 | Interest on Capital Indebtedness | 16100 | | | | | |
| 58 | Start-up Expenses | 16110 | | | | | |
| 59 | MCFFA/DASNY Interest Expense | 16120 | | | | | |
| 60 | MCFFA/DASNY Administration Fees | 16130 | | | | | |
| 61 | Maintenance in Lieu of Rent (LGU only) | 16140 | | | | | |
| 62 | Other (Detail Required) | 16998 | | | | | |
| 63 | Total Property-Provider Paid (Sum of Lines 49-62) | 16999 | | | | | |
| | **TOTALS** | | | | | | |
| 64 | Total Operating Costs (Sum lines 16, 17, 20, 41 minus 29) | 19010 | | | | | |
| 65 | Agency Admin. Alloc.(Line 64 times .__ __ __ __ __ __)* | 19050 | | | | | |
| 66 | Adjustments/Non-Allowable Costs (Detail Required) | 19030 | | | | | |
| 67 | Total Prog/Site Costs (Sum lines 29, 48, 63-65 minus 66) | 19060 | | | | | |
| | **OMRDD Only - Informational** | | | | | | |
| 68a | Other Than To/From Transportation Allocation | 19101 | | | | | |
| 68b | To/From Transportation Allocation | 19102 | | | | | |
| 68c | ICF/DD SED Contract Liability | 19103 | | | | | |
| 68d | ICF/DD Day Services Liability | 19104 | | | | | |

*** The applicable 6 digit adjusted ratio value factor from CFR-3.2, line 65 through 69. Agency administration should not be allocated to programs 0190, 0880, 0890 and state agency specific programs which are exempt from agency administration.**

Funding State Agency:
☐ OMH ☐ SED
☐ OMRDD
☐ OASAS

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
*For the Period: July 1, 2008 to June 30, 2009*

**SCHEDULE CFR-1**
**PROGRAM/SITE DATA**



**AGENCY NAME:**_____

**AGENCY CODE:**_____

**SCHOOL CODE: (SED ONLY)** __ __ __ __ __ __ __ __ __ __ __ __

| Line No. | COLUMN NUMBER / ITEM DESCRIPTION | Cost Codes | | | | | |
|---|---|---|---|---|---|---|---|
| | **Program Code (Program Code Index)** | 00010 | ( ) | ( ) | ( ) | ( ) | ( ) |
| | **Program/Site Identification Number** | 00050 | | | | | |
| **SECTION C: REVENUES** | | | | | | | |
| **69** | Participant Fee (less SSI & SSA) | **20010** | | | | | |
| **70** | SSI & SSA | **20020** | | | | | |
| **71** | Home Relief/Public Assistance | **20030** | | | | | |
| **72** | Medicaid | **20040** | | | | | |
| **73** | Medicare | **20060** | | | | | |
| **74** | Other Third Parties (Detail Required) | **20070** | | | | | |
| **75** | OMRDD Residential Room and Board/NYS OPTS | **20080** | | | | | |
| **76** | Transportation, Medicaid | **20090** | | | | | |
| **77** | Transportation, Other (Detail Required) | **20100** | | | | | |
| **78** | Sales: Contract Total | **21070** | | | | | |
| **79** | Federal Grants (Detail Required) | **22040** | | | | | |
| **80** | State Grants (Detail Required) | **22030** | | | | | |
| **81** | LTSE Income Total (OMH and OMRDD only) | **22080** | | | | | |
| **82** | Food Stamps (OASAS Only)/Food Revenue (SED Only) | **22160** | | | | | |
| **83** | Gifts, Legacies, Bequests, Restricted Donations | **22010** | | | | | |
| **84** | Section 202/8/811 HUD Funds* | **22020** | | | | | |
| **85** | Interest/Dividend Income | **22050** | | | | | |
| **86** | Prior Period Rate Adjustments** | **22090** | | | | | |
| **87** | Excessive Teacher Turnover Prevention Grant (SED only) | **22100** | | | | | |
| **88** | LDSS County Revenue (SED only) | **22110** | | | | | |
| **89** | 4402 Revenue (School District In-State) (SED only) | **22120** | | | | | |

*** For OMRDD programs, if this line is completed, complete Schedule OMRDD-3 (HUD Revenues and Expenses).**
**** Refer to CFR manual for specific instructions.**

Funding State Agency:
☐ OMH ☐ SED
☐ OMRDD
☐ OASAS

# NEW YORK STATE
**CONSOLIDATED FISCAL REPORT**
***For the Period: July 1, 2008 to June 30, 2009***

**SCHEDULE CFR-1**
**PROGRAM/SITE**
**DATA**



**AGENCY NAME:**_____
**AGENCY CODE:**_____
**SCHOOL CODE: (SED ONLY)** __ __ __ __ __ __ __ __ __ __ __ __

| Line No. | COLUMN NUMBER / ITEM DESCRIPTION | Cost Codes | | | | | |
|---|---|---|---|---|---|---|---|
| | **Program Code (Program Code Index)** | 00010 | ( ) | ( ) | ( ) | ( ) | ( ) |
| | **Program/Site Identification Number** | 00050 | | | | | |
| 90 | Department of Health Chapter 428 Revenue (SED only) | 22130 | | | | | |
| 91 | 4408 Revenue (School District) (SED only) | 22140 | | | | | |
| 92 | 4410 Revenue (Preschool) (SED only) | 22150 | | | | | |
| 93 | Net Deficit Funding (State & LGU Funding only)* | 20110 | | | | | |
| 94 | Other (Detail Required) | 22998 | | | | | |
| 95 | Gross Revenues (Sum Lines 69-94) | 23999 | | | | | |
| | **GAAP ADJUSTMENTS TO REVENUE** | | | | | | |
| 96 | Participant Allowance | 24010 | | | | | |
| 97 | Uncollectible Accounts Receivable | 24040 | | | | | |
| 98 | Other (Detail Required) | 24996 | | | | | |
| 99 | Total GAAP Adjustments (Sum Lines 96-98) | 24997 | | | | | |
| 100 | Net GAAP Revenues (Line 95 minus 99) | 24998 | | | | | |
| | **NON-GAAP ADJUSTMENTS TO REVENUE** | | | | | | |
| 101 | Exempt Contract Income | 24050 | | | | | |
| 102 | Exempt LTSE Income | 24060 | | | | | |
| 103 | Net Deficit Funding** | 24070 | | | | | |
| 104 | Other (Detail Required) | 24080 | | | | | |
| 105 | Total NON-GAAP Adjustments (Sum Lines 101-104) | 24097 | | | | | |
| 106 | **TOTAL ADJ. TO REVENUE (Sum Lines 99 & 105)** | 24999 | | | | | |
| 107 | **TOTAL NET REVENUES (Line 95 minus 106)** | 25999 | | | | | |

*** Do not include non-funded or voluntary contributions.**
**** Amounts should equal the corresponding amounts reported as revenue on line 93 above.**

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
***For the Period: July 1, 2008 to June 30, 2009***

**SCHEDULE CFR-2**
**AGENCY FISCAL SUMMARY**



**AGENCY NAME:**_____
**AGENCY CODE:**_____
**SCHOOL CODE: (SED ONLY)** __ __ __ __ __ __ __ __ __ __ __ __

**THE RECONCILIATION SCHEDULE MUST BE COMPLETED WHEN:**
(1) the expenses and revenues in the CFR do not equal the expenses and revenues in the audited financial statements and
(2) the reporting periods of the CFR and financial statements coincide.

| Line No. | COLUMN NUMBER / ITEM DESCRIPTION / EXPENSES | Cost Codes | 1 AGENCY TOTALS (Sum Col. 2-7) | 2 OASAS TOTALS | 3 OMH TOTALS | 4 OMRDD TOTALS | 5 SED TOTALS | 6 SHARED PROGRAM TOTALS | 7 OTHER PROGRAMS TOTALS* |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Personal Services (CFR-1, Line 16) | 31999 | | | | | | | |
| 2 | Vacation Leave Accruals (CFR-1, Line 17) | 32999 | | | | | | | |
| 3 | Fringe Benefits (CFR-1, Line 20) | 33999 | | | | | | | |
| 4 | OTPS (CFR-1, Line 41) | 34999 | | | | | | | |
| 5 | Equipment-Provider Paid (CFR-1, Line 48) | 35999 | | | | | | | |
| 6 | Property-Provider Paid (CFR-1, Line 63) | 36999 | | | | | | | |
| 7 | Net Agency Admin. (CFR-1, Line 65) | 38050 | | | | | | | |
| 8 | Adj./Non-Allow. Costs (CFR-1, Line 66) | 38030 | | | | | | | |
| 9 | Total Adj. Expenses (Sum Lines 1-7 minus 8) | 38999 | | | | | | | |
| | **REVENUES** | | | | | | | | |
| 10 | Gross Revenues (CFR-1, Line 95) | 40999 | | | | | | | |
| 11 | GAAP Adj. to Revenue (CFR-1, Line 99) | 43999 | | | | | | | |
| 12 | Net GAAP Revenues (Line 10 minus Line 11) | 44999 | | | | | | | |

*** These amounts are not detailed elsewhere in the CFR and, therefore, will not crossfoot to CFR-1.**

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
***For the Period: July 1, 2008 to June 30, 2009***

**SCHEDULE CFR-3**
**AGENCY ADMINISTRATION**

**Page _____**

**AGENCY NAME:**_____ **SCHOOL CODE: (SED ONLY)** __ __ __ __ __ __ __ __ __ __ __ __

**AGENCY CODE:**_____

| Line No. | ITEM DESCRIPTION | COST CODES | AGENCY ADMIN TOTALS |
|---|---|---|---|
| | **PERSONAL SERVICES** | | |
| 1 | Total Personal Services (from CFR-4, Agency Admin.) | 11998 | |
| 2 | Vacation Leave Accruals | 12998 | |
| | | | |
| | **FRINGE BENEFITS** | | |
| 3 | Mandated Fringe Benefits | 13201 | |
| 4 | Non-Mandated Fringe Benefits | 13301 | |
| 5 | Total Fringe Benefits (Sum Lines 3 - 4) | 13998 | |
| | | | |
| | **OTHER THAN PERSONAL SERVICES (OTPS)** | | |
| 6 | Audit/Legal | 14200 | |
| 7 | Utilities | 14210 | |
| 8 | Telephone | 14220 | |
| 9 | Repairs and Maintenance | 14021 | |
| 10 | Office Supplies and Postage | 14161 | |
| 11 | Organizational Expense | 14230 | |
| 12 | Interest - Working Capital | 14240 | |
| 13 | Expensed Equipment | 14081 | |
| 14 | Contracted Personal Services | 14151 | |
| 15 | Staff Travel | 14251 | |
| 16 | Insurance - General | 14261 | |
| 17 | Other (Detail Required) | 14997 | |
| 18 | Total OTPS (Sum Lines 6 - 17) | 14996 | |
| | | | |
| | **EQUIPMENT-PROVIDER PAID** | | |
| 19 | Lease/Rental-Vehicle | 15011 | |
| 20 | Lease/Rental-Equipment | 15030 | |

| Line No. | ITEM DESCRIPTION | COST CODES | AGENCY ADMIN TOTALS |
|---|---|---|---|
| | **EQUIPMENT-PROVIDER PAID (CONTINUED)** | | |
| 21 | Depreciation-Vehicle | 15041 | |
| 22 | Depreciation-Equipment | 15060 | |
| 23 | Interest-Vehicle | 15071 | |
| 24 | Other (Detail Required) | 15997 | |
| 25 | Total Equipment (Sum Lines 19 - 24) | 15996 | |
| | | | |
| | **PROPERTY-PROVIDER PAID** | | |
| 26 | Lease/Rental-Real Property | 16011 | |
| 27 | Leasehold/Leasehold Improvements | 16021 | |
| 28 | Depreciation-Building | 16031 | |
| 29 | Depreciation-Building/Land Improvements | 16050 | |
| 30 | Mortgage Interest | 16061 | |
| 31 | Mortgage Expenses | 16071 | |
| 32 | Insurance-Property & Casualty | 16081 | |
| 33 | Real Estate Taxes | 16091 | |
| 34 | Maintenance in Lieu of Rent (LGU only) | 16141 | |
| 35 | Interest on Capital Indebtedness | 16101 | |
| 36 | Other (Detail Required) | 16997 | |
| 37 | Total Property (Sum Lines 26 - 36) | 16996 | |
| | | | |
| 38 | Parent Agency Administration Allocation | 19070 | |
| 39 | County Wide Cost Allocation (LGU Only) | 19080 | |
| 40 | Total Agency Administration (Sum Lines 1,2,5,18,25,37,38,39) | 19090 | |
| 41 | Adjustments/Non-Allowable Costs (Detail Required) | 19031 | |
| 42 | Net Agency Administration (Line 40 minus 41) | 19998 | |

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
*For the Period: July 1, 2008 to June 30, 2009*

**SCHEDULE CFR-3**
**AGENCY**
**ADMINISTRATION**

Page _____

AGENCY NAME:_____ SCHOOL CODE: (SED ONLY) __ __ __ __ __ __ __ __ __ __ __ __

AGENCY CODE:_____

### RATIO VALUE WORKSHEET (AGENCY-WIDE)

| Line No. | State Agency | Cost Codes | Amount |
|---|---|---|---|
| **CALCULATION OF OPERATING COSTS *** | | | |
| 43 | OASAS Subtotal | 19110 | |
| 44 | OMH Subtotal | 19120 | |
| 45 | OMRDD Subtotal | 19130 | |
| 46 | SED Subtotal | 19140 | |
| 47 | Shared Programs Subtotal | 19150 | |
| 48 | Other Programs Subtotal** | 19160 | |
| 49 | Total Agency Operating Costs | 19170 | |
| **CALCULATION OF RATIO VALUE FACTOR** | | | |
| 50 | Net Agency Administration (CFR-3, Line 42) | 19999 | |
| 51 | Total Agency Operating Costs (CFR-3, Line 49) | 19171 | |
| 52 | Ratio Value Factor (Line 50 divided by line 51) | 19180 | |
| **ALLOCATION OF AGENCY ADMINISTRATION USING RATIO VALUE *** | | | |
| 53 | OASAS Allocation (line 43 x line 52) | 19210 | |
| 54 | OMH Allocation (line 44 x line 52) | 19220 | |
| 55 | OMRDD Allocation (line 45 x line 52) | 19230 | |
| 56 | SED Allocation (line 46 x line 52) | 19240 | |
| 57 | Shared Programs Allocation (line 47 x line 52) | 19250 | |
| 58 | Other Programs Allocation (line 48 x line 52) | 19260 | |
| 59 | Total Agency Administration ( sum lines 53 - 58) | 19270 | |

### ADJUSTED RATIO VALUE WORKSHEET (WITHIN STATE AGENCY)

| Line No. | State Agency | Cost Codes | Amount |
|---|---|---|---|
| **CALCULATION OF ADJUSTED OPERATING COSTS **** | | | |
| 60 | OASAS Adjusted Subtotal | 19310 | |
| 61 | OMH Adjusted Subtotal | 19320 | |
| 62 | OMRDD Adjusted Subtotal | 19330 | |
| 63 | SED Adjusted Subtotal | 19340 | |
| 64 | Shared Programs Adjusted Subtotal | 19350 | |
| **CALCULATION OF ADJUSTED RATIO VALUE FACTOR ***** | | | |
| 65 | OASAS Ratio Value Factor (line 53 divided by line 60) | 19410 | |
| 66 | OMH Ratio Value Factor (line 54 divided by line 61) | 19420 | |
| 67 | OMRDD Ratio Value Factor (line 55 divided by line 62) | 19430 | |
| 68 | SED Ratio Value Factor (line 56 divided by line 63) | 19440 | |
| 69 | Shared Programs Ratio Value Factor (line 57 divided by line 64) | 19450 | |

* Totals by State Agency from CFR-1, Line 64. Do not report operating costs for programs 0190, 0880 and 0890.

** This amount must equal the sum of lines 1 through 4 of column 7 on schedule CFR-2. These amounts are not detailed elsewhere in the CFR and, therefore, will not cross foot to CFR-1.

*** For each state agency, the sum of agency administration allocated to each program/site on CFR-1, line 65, must equal the agency administration calculated below.

**** Totals by State Agency from CFR-1, Line 64. Do not report operating costs for programs 0190, 0880 and 0890 and programs which are exempt from agency administration.
For OMH (line 61) , do not include operating costs for programs 0860, 0870, 1690, 2820, 2830, 2860, 8810 and programs with an "A" program code index (startup).
For OMRDD Specific (line 62), do not include operating costs for programs 2091and 5091.

***** The adjusted ratio value factor for each State Agency should appear in the item description column of that State Agency specific CFR-1, line 65.

Funding State Agency:
☐ OMH ☐ SED
☐ OMRDD
☐ OASAS

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
*For the Period: July 1, 2008 to June 30, 2009*

**SCHEDULE CFR-4**
**PERSONAL SERVICES**

Page _____

**AGENCY NAME:**_____
**AGENCY CODE:**_____
**SCHOOL CODE: (SED ONLY)** __ __ __ __ __ __ __ __ __ __ __ __

**FTE'S MUST BE CALCULATED TO 3 DECIMAL PLACES.**

Provide all applicable information. Refer to Appendix R for Position Title Codes and Definitions. Indicate the standard work week or provide the number of hours in the "other" column.
Indicate the applicable staffing category on the line below to which each page applies.

**PROGRAM/SITE-PROGRAM ADMIN./LGU ADMIN. (Position Title Codes 100-599 and 700-799 series) ____** **AGENCY ADMINISTRATION (Position Title Codes 600-699 series) ____***

| Position Title Code Appendix R | COLUMN NUMBER | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | PROGRAM CODE ** (PROGRAM CODE INDEX) | | | | | ( ) | | | ( ) | | | ( ) | | | ( ) | | | ( ) | | |
| | PROGRAM/SITE IDENTIFICATION NUMBER ** | | | | | | | | | | | | | | | | | | | |
| | PROGRAM/SITE NAME | | | | | | | | | | | | | | | | | | | |
| | PROGRAM/SITE ADDRESS (Line One) | | | | | | | | | | | | | | | | | | | |
| | PROGRAM/SITE ADDRESS (Line Two) | | | | | | | | | | | | | | | | | | | |
| | COUNTY CODE | | | | | | | | | | | | | | | | | | | |
| | Position Title | Standard Work Week | | | | Hours Paid | FTE | Amount Paid | Hours Paid | FTE | Amount Paid | Hours Paid | FTE | Amount Paid | Hours Paid | FTE | Amount Paid | Hours Paid | FTE | Amount Paid |
| | | 35 | 37.5 | 40 | Other | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| Total "Hours Paid", "FTE" and "Amount Paid" for Positions. | | | | | | | | | | | | | | | | | | | | |

*** Report Agency Administration in one column on a separate page.**
**** For OASAS, program code = service level and program/site = PRU level.**
**Totals are transferred to Schedule CFR-1 Line 16 (Program/Site, Program Administration & LGU Administration), or Schedule CFR-3 Line 1 (Agency Administration).**
**Note: FTE's do not get transferred.**

Funding State Agency:
☐ OMH ☐ SED
☐ OMRDD
☐ OASAS

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
*For the Period: July 1, 2008 to June 30, 2009*

**SCHEDULE CFR-4A**
**CONTRACTED DIRECT CARE AND CLINICAL PERSONAL SERVICES**



**AGENCY NAME:**_____
**AGENCY CODE:**_____
**SCHOOL CODE: (SED ONLY)** __ __ __ __ __ __ __ __ __ __ __ __

Refer to Appendix R for Position Title Codes and definitions.
**Report only program/site specific positions (Position Title Codes 200-399 series).**

| Position Title Code Appendix R | COLUMN NUMBER | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | PROGRAM CODE (PROGRAM CODE INDEX) | ( ) | | ( ) | | ( ) | | ( ) | | ( ) | |
| | PROGRAM/SITE IDENTIFICATION NUMBER | | | | | | | | | | |
| | PROGRAM/SITE NAME | | | | | | | | | | |
| | PROGRAM/SITE ADDRESS (Line One) | | | | | | | | | | |
| | PROGRAM/SITE ADDRESS (Line Two) | | | | | | | | | | |
| | COUNTY CODE | | | | | | | | | | |
| | Position Title | Hours Paid | Amount Paid | Hours Paid | Amount Paid | Hours Paid | Amount Paid | Hours Paid | Amount Paid | Hours Paid | Amount Paid |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| Total "Hours Paid" and "Amount Paid" for Positions. | | | | | | | | | | | |

**Totals are transferred to Schedule CFR-1 Line 35 (Program/Site).**

# NEW YORK STATE

**CONSOLIDATED FISCAL REPORT**

***For the Period: July 1, 2008 to June 30, 2009***

**SCHEDULE CFR-5**
**TRANSACTIONS WITH RELATED ORGANIZATIONS/INDIVIDUALS**



**AGENCY NAME:**_____ **AGENCY CODE:** _____ **SCHOOL CODE: (SED ONLY)** __ __ __ __ __ __ __ __ __ __ __ __

***SECTION A:*** ***NOTE: (OASAS and OMRDD providers only): For purposes of this schedule, "related organizations and/or individuals" shall include closely allied entities as described and defined in Article 25.06 of Mental Hygiene Law and on page 18.2 of the CFR Manual. OASAS providers are also directed to refer to Local Services Bulletin 1999-02.***

**Question #1:** **During the reporting period, were there any PAYMENTS TO related organizations or individuals associated with the provider that involved any OASAS, OMH, OMRDD and/or SED programs and/or agency administration? YES _____ NO _____ If yes, Sections B and C of this schedule must be completed.**

**Question #2:** **(Applies only to OASAS and OMRDD service providers) During the reporting period, were there any transactions with related organizations or individuals FROM WHICH the service provider received any financial aid/assistance or TO WHICH the service provider provided financial aid/assistance? YES ___ NO ___ If yes, Section D must be completed.**

***SECTION B:*** **Please list all PAYMENTS TO related organizations and/or individuals below:**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|
| Line No. | Item No. | PROGRAM/SITES AFFECTED ENTER PROG/SITE ID# (CODE) OR ADMINISTRATION | DESCRIPTION OF TRANSACTION | NAME OF RELATED ORGANIZATION/INDIVIDUAL | RELATIONSHIP TO PROVIDER* | AMOUNT OF TRANSACTION REPORTED | ALLOWABLE COSTS | ADJUSTMENTS TO COSTS (COL. 7 MINUS 8) |
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |

***SECTION C:*** **For space lease/rental agreements listed in section B above, detail the related organization's/individual's allowable costs reported in section B, col. 8 above:**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|
| Line No. | Item No. | PROGRAM/SITES AFFECTED ENTER PROG/SITE ID# (CODE) OR ADMIN. | DEPRECIATION | MORTGAGE INTEREST | INSURANCE | PROPERTY TAXES | OTHER (SPECIFY) | TOTAL ALLOWABLE COSTS |
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |

***SECTION D:*** **(This section applies only to OASAS and OMRDD service providers.) Report each related party/related individual FROM WHICH the service provider received any financial aid or assistance or TO WHICH the service provider provided any financial aid or assistance.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | | 8 |
|---|---|---|---|---|---|---|---|---|
| | | | | | | Funding | | Funding To/From |
| Line # | Item # | Name of Related Party/Individual | Street Address | City, State | Type of Financial Support/Aid | To | From | Amount |
| 1 | | | | | | ☐ | ☐ | |
| 2 | | | | | | ☐ | ☐ | |
| 3 | | | | | | ☐ | ☐ | |
| 4 | | | | | | ☐ | ☐ | |
| 5 | | | | | | ☐ | ☐ | |

*** See section 18.0 of the CFR Manual for the relationship key.**

# NEW YORK STATE
**CONSOLIDATED FISCAL REPORT**
***For the Period: July 1, 2008 to June 30, 2009***

**SCHEDULE CFR-6**
**GOVERNING BOARD AND**
**COMPENSATION SUMMARY**



**AGENCY NAME:** _____ **AGENCY CODE:** _____ **SCHOOL CODE (SED ONLY):** __ __ __ __ __ __ __ __ __ __ __ __

1. **Do any employees of your agency also serve on the governing authority? ___ YES ___ NO If "YES", provide detail of the employee name and position title.**
2. **List the names of all individuals who receive compensation as Board Officers, Members of the Board of Directors or Board Trustees:**

| | NAME | AMOUNT PAID | CONTRACTED PAYMENT AMOUNT | FRINGE BENEFITS | OTHER BENEFITS ** | TOTAL COMPENSATION |
|---|---|---|---|---|---|---|
| A. | | | | | | |
| B. | | | | | | |
| C. | | | | | | |
| D. | | | | | | |
| E. | | | | | | |

3. **List the five highest paid employees whose total annualized salary and contracted payment amount (column 7) is in excess of $50,000 per year**

**AND**

**ALL employees whose total annualized salary and contracted payment (column 7) is in excess of $125,000 per year.**

| | (1) NAME | (2) POSITION TITLE CODE * | (3) AMOUNT PAID | (4) FTE | (5) ANNUALIZED SALARY | (6) CONTRACTED PAYMENT AMOUNT | (7) TOTAL ANNUALIZED SALARY AND CONTRACTED PAYMENT | (8) FRINGE BENEFITS | (9) OTHER BENEFITS ** |
|---|---|---|---|---|---|---|---|---|---|
| A. | | ☐ | | | | | | | |
| B. | | ☐ | | | | | | | |
| C. | | ☐ | | | | | | | |
| D. | | ☐ | | | | | | | |
| E. | | ☐ | | | | | | | |

4. **List the five highest paid independent contractors (individual or firm) that received payments in excess of $50,000.**

| | (1) NAME | (2) TYPE OF SERVICE | (3) AMOUNT PAID |
|---|---|---|---|
| A. | | | |
| B. | | | |
| C. | | | |
| D. | | | |
| E. | | | |

5. **Number of additional employees and independent contractors whose annualized salary and/or contracted payment amount is in excess of $50,000.** _____

* **If an individual is reported under more than one position title code on CFR-4, please check the box in column 2.**
** **Cash value of awards, rewards, loans or other benefits made in lieu of, or in addition to, monetary compensation or regular fringe benefits. Regular fringe benefits are received by all classes or categories of employees. (e.g.: Payroll Taxes)**