

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: January 1, 2009 TO December 31, 2009

AGENCY NAME: Any Agency Inc.  
AGENCY ADDRESS: 24 Phillips St.  
Syracuse, New York 13211-2319  
 Please check the box if the agency address changed from the prior reporting period.

AGENCY CODE: 11110  
COUNTY NAME: Onondaga  
COUNTY CODE: 34

TYPE OF OWNERSHIP:  
NOT-FOR-PROFIT:    
PROPRIETARY:    
GOVERNMENTAL:

Person to Contact with Regard to Questions Concerning this Report:

Ms. Sally Sanders 315 556-5555 Ext. 123  
-----  
Name Telephone Number  
  
Controller 315 556-5577  
-----  
Title FAX Number  
  
ssanders@anyagency.com  
-----  
E-mail Address

SCHOOL CODE (SED ONLY): 010205005555

FEDERAL EMPLOYER ID NUMBER: 14-2345678

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

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

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

CERTIFICATION STATEMENT  
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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.

04/15/2010  
-----  
Date

315 553-5454 Ext. 133  
-----  
Telephone Number

Mrs. Mary Reynolds - Executive Director  
-----  
Name and Title  
  
mreynolds@anyagency.com  
-----  
E-mail Address

-----  
Signature of Director  
 Please check the box if the Director changed from the prior reporting period.

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: January 1, 2009 TO December 31, 2009

SCHEDULE CFR-ii  
ACCOUNTANT'S REPORT  
VOLUNTARY AGENCY or  
COUNTY GOVERNMENT  
PAGE 2

AGENCY NAME: Any Agency Inc.

AGENCY CODE: 11110

SCHOOL CODE (SED ONLY): 010205005555

We have audited the accompanying balance sheet of the Agency/County as of December 31, 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 December 31, 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 51610028 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 51610028, 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 December 31, 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 December 31, 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 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 above 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.

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SCHEDULE CFR-ii  
ACCOUNTANT'S REPORT  
VOLUNTARY AGENCY or  
COUNTY GOVERNMENT  
PAGE 3

04/14/2010

-----  
Date CFR-ii signed

-----  
Date of Report (Enter the date of the audit report on the financial  
statements.)

315 222-3535 Ext. 25

-----  
Telephone Number

-----  
Signature of Independent Accountant, Firm, or Sole Practitioner  
Alexandria Countit

A. Countit & Company

-----  
Firm Name

66 Wall St.  
Homer, NY 13222

-----  
Address

-----  
Firm Contact Person

1234567

-----  
CPA Firm Registration Number

AGENCY NAME: Any Agency Inc.

AGENCY CODE: 11110

COUNTY/NYC - OPERATED OR VOLUNTARY LOCAL SERVICE PROVIDER CERTIFICATION  
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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: _____	Signed: _____
(For Voluntary Local Service Provider)	(For County/City Operated Local Service Provider)
Executive Director	
Title: _____	Title: _____
(Service Provider's Chief Executive Officer)	(LGU's Chief Fiscal Officer)
04/15/2010	
Date: _____	Date: _____

LOCAL GOVERNMENTAL UNIT CERTIFICATION  
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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 Onondaga - 34
Unit: _____
Date: _____

Funding State Agency:  
 OMH     SED  
 OMRDD  
 OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
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SCHEDULE CFR-1  
 PROGRAM/SITE  
 DATA

AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 SCHOOL CODE: (SED ONLY)

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3	4
SECTION A: GENERAL INFORMATION						
1) Program Type	00070 Continuing Day Treatment			Advocacy/Support Services	Advocacy/Support Services	Community Residence, Children
2) Program Code (Program Code Index)	00010 1310 (00)			1760 (00)	1760 (00)	7050 (00)
3) Program/Site Identification Number	00050 1111052			1111050	1111276	1111975
4) Program/Site Name	00020 OMH CDT			OMH Answers	OMH Shoulders	Regency House
5) Program/Site Address (Line One)	00030 25 Bunn St			25 Stewart St.	22 My Way Drive	25 Euclid Ave.
6) Program/Site Address (Line Two)	00040 Syracuse, NY 13210-2330			Syracuse, NY 13209-2541	Syracuse, NY 13211-2145	Syracuse, NY 13292-1105
7) Medicaid Provider Agreement Number (DMH only)	00060 14141414					01305850
8) County Code (See Appendix C)	00080 34			34	34	34
9) Date Site Opened	00090 02/02/1992			06/01/1996	01/01/2001	01/16/1991
10) Certified Capacity (OASAS, OMRDD and SED only)	00100		0	0	0	0
11) Actual Capacity (OMH, OMRDD and SED only)	00110		0	0	0	8
12) Actual Days Program/Site Open	00160		251	135	135	365
13) Units Of Service	00120		19,005	839	860	2,628
14) Respite or TUBS Units of Service (OMRDD only)	00130		0	0	0	0
15) Program/Site Square Footage (OASAS, OMRDD and SED Only)	00150		0	0	0	0

Funding State Agency:  
 OMH     SED  
 OMRDD  
 OASAS

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SCHEDULE CFR-1  
 PROGRAM/SITE  
 DATA

-----  
 AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 SCHOOL CODE: (SED ONLY)  
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Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3	4
	Program Code (Program Code Index)		1310 (00)	1760 (00)	1760 (00)	7050 (00)
	Program/Site Identification Number		1111052	1111050	1111276	1111975
SECTION B: EXPENSES						
PERSONAL SERVICES						
16)	Personal Services-Program/Site & Program Admin*	11999	471,265	24,163	21,818	578,598
17)	Vacation Accruals-Program/Site & Program Admin*	12999	685	414	431	1,312
FRINGE BENEFITS						
18)	Mandated Fringe Benefits	13200	56,520	3,273	2,723	75,906
19)	Non-Mandated Fringe Benefits	13300	37,680	1,376	1,245	45,901
20)	Total Fringe Benefits (Sum Lines 18 & 19)	13999	94,200	4,649	3,968	121,807
OTHER THAN PERSONAL SERVICES (OTPS)						
21)	Food	14010	0	0	0	17,861
22)	Repairs and Maintenance	14020	30,412	272	272	11,204
23)	Utilities	14030	24,737	681	681	9,522
24)	Transportation Related - Participant**	14040	0	16	16	11,176
25)	Staff Travel	14250	120	1,950	1,211	134
26)	Participant Incidentals	14050	7,804	0	0	3,903
27)	Expensed Adaptive Equipment (OMRDD and SED only)	14070	0	0	0	0
28)	Expensed Equipment	14080	1,768	83	23	0
29)	Sub-Contract Raw Materials	14090	0	0	0	0
30)	Participant Wages - Non-Contract	14100	0	0	0	0

Funding State Agency:  
 OMH     SED  
 OMRDD  
 OASAS

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SCHEDULE CFR-1  
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 DATA

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 AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 SCHOOL CODE: (SED ONLY)  
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Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3	4
	Program Code (Program Code Index)		1310 (00)	1760 (00)	1760 (00)	7050 (00)
	Program/Site Identification Number		1111052	1111050	1111276	1111975
31)	Participant Wages-Contract	14110	0	0	0	0
32)	Participant Fringe Benefits	14120	0	0	0	0
33)	Section 43.04 Services Assessment (OMRDD only)	14130	0	0	0	0
34)	Staff Development	14140	3,628	45	184	3,255
35)	Contracted Direct Care and Clinical Personal Services (from CFR-4A)	14150	58,885	0	0	0
36)	Supplies and Materials - Non-Household	14160	14,348	81	43	1,587
37)	Household Supplies	14170	3,524	182	181	5,517
38)	Telephone	14190	8,908	231	228	7,033
39)	Insurance - General	14260	3,182	17	17	3,295
40)	Other (Detail Required)	14998	7,692	127	127	0
41)	Total Other Than Personal Services (Sum Lines 21-40)	14999	165,008	3,685	2,983	74,487
	EQUIPMENT - PROVIDER PAID					
42)	Lease/Rental Vehicle	15010	0	0	0	0
43)	Lease/Rental Equipment	15020	0	0	0	0
44)	Depreciation - Vehicle	15040	0	21	21	1,221
45)	Depreciation - Equipment	15050	0	126	126	0
46)	Interest - Vehicle	15070	0	0	0	0
47)	Other (Detail Required)	15998	0	0	0	0
48)	Total Equipment (Sum Lines 42-47)	15999	0	147	147	1,221
	PROPERTY - PROVIDER PAID					
49)	Lease/Rental - Real Property	16010	68,620	1,105	1,205	0
50)	Leasehold/Leasehold Improvements	16020	0	0	0	0
51)	Depreciation - Building	16030	0	0	0	12,674
52)	Depreciation - Building/Land Improvements	16040	0	0	0	0

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 OASAS

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SCHEDULE CFR-1  
 PROGRAM/SITE  
 DATA

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 AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 SCHOOL CODE: (SED ONLY)  
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Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3	4
	Program Code (Program Code Index)		1310 (00)	1760 (00)	1760 (00)	7050 (00)
	Program/Site Identification Number		1111052	1111050	1111276	1111975
53)	Mortgage/Cap Imprv Interest (Report MCFFA Bond Int. on Line 59)	16060	0	0	0	0
54)	Mortgage Expenses	16070	0	0	0	0
55)	Insurance - Property & Casualty	16080	0	300	200	3,013
56)	Real Estate Taxes	16090	0	0	0	848
57)	Interest on Capital Indebtedness	16100	0	0	0	0
58)	Start-Up Expenses	16110	0	0	0	0
59)	MCFFA/DASNY Interest Expense	16120	0	0	0	19,256
60)	MCFFA/DASNY Administration Fees	16130	0	0	0	0
61)	Maintenance in Lieu of Rent (LGU Only)	16140	0	0	0	0
62)	Other (Detail Required)	16998	0	0	0	1,522
63)	Total Property-Provider Paid (Sum of Lines 49-62)	16999	68,620	1,405	1,405	37,313
TOTALS						
64)	Total Operating Costs (Sum lines 16,17,20,41 minus 29)	19010	731,158	32,911	29,200	776,204
65)	Agency Admin. Alloc.* (Line 64 times 0.097691)	19050	71,428	3,215	2,853	75,828
66)	Adjustments/Non-Allowable Costs (Detail Required)	19030	0	0	0	0
67)	Total Prog/Site Costs (Sum lines 29, 48, 63-65 minus 66)	19060	871,206	37,678	33,605	890,566
OMRDD Only - Informational						
68a)	Other Than To/From Transportation Allocation	19101	0	0	0	0
68b)	To/From Transportation Allocation	19102	0	0	0	0
68c)	ICF/DD SED Contract Liability	19103	0	0	0	0
68d)	ICF/DD Day Services Liability	19104	0	0	0	0

\* 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:  
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 OMRDD  
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SCHEDULE CFR-1  
 PROGRAM/SITE  
 DATA

-----  
 AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 SCHOOL CODE: (SED ONLY)  
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Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3	4
	Program Code (Program Code Index)		1310 (00)	1760 (00)	1760 (00)	7050 (00)
	Program/Site Identification Number		1111052	1111050	1111276	1111975
SECTION C: REVENUES						
69)	Participant Fee (Less SSI & SSA)	20010	0	0	0	0
70)	SSI and SSA	20020	0	0	0	69,505
71)	Home Relief/Public Assistance	20030	0	0	0	0
72)	Medicaid	20040	935,128	0	0	816,070
73)	Medicare	20060	0	0	0	0
74)	Other Third Parties (Detail Required)	20070	1,278	0	0	0
75)	OMRDD Residential Room and Board/NYS OPTS	20080	0	0	0	0
76)	Transportation, Medicaid	20090	0	0	0	0
77)	Transportation, Other (Detail Required)	20100	0	0	0	0
78)	Sales: Contract Total	21070	0	0	0	0
79)	Federal Grants (Detail Required)	22040	0	0	0	0
80)	State Grants (Detail Required)	22030	0	0	0	0
81)	LTSE Income Total (OMH and OMRDD only)	22080	0	0	0	0
82)	Food Stamps (OASAS, OMRDD), Food Revenue (SED Only)	22160	0	0	0	0
83)	Gifts, Legacies, Bequests, Restricted Donations	22010	0	0	0	1,050
84)	Section 202/8/811 HUD Funds *	22020	0	0	0	0
85)	Interest/Dividend Income	22050	0	0	0	0
86)	Prior Period Rate Adjustments**	22090	0	0	0	0
87)	Excessive Teacher Turnover Prevention Grant (SED only)	22100	0	0	0	0
88)	LDSS County Revenue (SED only)	22110	0	0	0	0
89)	4402 Revenue (School District In-State)(SED only)	22120	0	0	0	0

\* 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  
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 OASAS

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SCHEDULE CFR-1  
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Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3	4
	Program Code (Program Code Index)		1310 (00)	1760 (00)	1760 (00)	7050 (00)
	Program/Site Identification Number		1111052	1111050	1111276	1111975
90)	Department of Health Chapter 428 Revenue (SED only)	22130	0	0	0	0
91)	4408 Revenue (School District)(SED only)	22140	0	0	0	0
92)	4410 Revenue (Preschool) (SED only)	22150	0	0	0	0
93)	Net Deficit Funding (State & LGU Funding only)*	20110	0	5,410	5,402	2,005
94)	Other (Detail Required)	22998	0	123	131	168
95)	Gross Revenues (Sum Lines 69-94)	23999	936,406	5,533	5,533	888,798
GAAP ADJUSTMENTS TO REVENUE						
96)	Participant Allowance	24010	0	0	0	0
97)	Uncollectible Accounts Receivable	24040	0	0	0	0
98)	Other (Detail Required)	24996	0	0	0	0
99)	Total GAAP Adjustments (Sum Lines 96-98)	24997	0	0	0	0
100)	Net GAAP Revenues (Line 95 minus 99)	24998	936,406	5,533	5,533	888,798
NON-GAAP ADJUSTMENTS TO REVENUE						
101)	Exempt Contract Income	24050	0	0	0	0
102)	Exempt LTSE Income	24060	0	0	0	0
103)	Net Deficit Funding**	24070	0	5,410	5,402	2,005
104)	Other (Detail Required)	24080	0	0	0	0
105)	Total NON-GAAP Adjustments (Sum Lines 101-104)	24097	0	5,410	5,402	2,005
106)	TOTAL ADJ. TO REVENUE (Sum Lines 99 & 105)	24999	0	5,410	5,402	2,005
107)	TOTAL NET REVENUES (Line 95 minus 106)	25999	936,406	123	131	886,793

\* Do not include non-funded or voluntary contributions.

\*\* Amounts should equal the corresponding amounts reported as revenue on line 93 above.

Funding State Agency:  
 OMH     SED  
 OMRDD  
 OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
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SCHEDULE CFR-1  
 PROGRAM/SITE  
 DATA

AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 SCHOOL CODE: 010205005555

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3	4	5
SECTION A: GENERAL INFORMATION							
1) Program Type	00070	Preschool-Special Class over		Preschool-Special Class over	Preschool-Sp Ed Itinerant Tea	Preschool-Sp Ed Itinerant Tea	Preschool-Evaluations
2) Program Code (Program Code Index)	00010	9100 (FF)		9100 (SS)	9135 (FF)	9135 (SS)	9190 (FF)
3) Program/Site Identification Number	00050	1111910		1111910	1111913	1111913	1111910
4) Program/Site Name	00020	Center (over 2.5 hrs)		Center (over 2.5 hrs)	Pre. Sch. Spec. Ed. Itinerant	Pre. Sch. Spec. Ed. Itinerant	Preschool Evauations
5) Program/Site Address (Line One)	00030	53 Bunn St		53 Bunn St	50 Valley Dr.	50 Valley Dr.	53 Bunn St
6) Program/Site Address (Line Two)	00040	Syracuse, NY 13210-2330		Syracuse, NY 13210-2330	Syracuse, NY 13210-2105	Syracuse, NY 13210-2105	Syracuse, NY 13210-2330
7) Medicaid Provider Agreement Number (DMH only)	00060						
8) County Code (See Appendix C)	00080	34		34	34	34	34
9) Date Site Opened	00090						
10) Certified Capacity (OASAS, OMRDD and SED only)	00100		24	24	0	0	0
11) Actual Capacity (OMH, OMRDD and SED only)	00110		24	24	13	13	0
12) Actual Days Program/Site Open	00160		0	0	0	0	0
13) Units Of Service	00120		0	0	215	216	133
14) Respite or TUBS Units of Service (OMRDD only)	00130		0	0	0	0	0
15) Program/Site Square Footage (OASAS, OMRDD and SED Only)	00150		3,000	3,000	0	0	0

Funding State Agency:  
 OMH     SED  
 OMRDD  
 OASAS

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SCHEDULE CFR-1  
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 DATA

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 AGENCY NAME: Any Agency Inc.  
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 -----

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3	4	5
	Program Code (Program Code Index)		9100 (FF)	9100 (SS)	9135 (FF)	9135 (SS)	9190 (FF)
	Program/Site Identification Number		1111910	1111910	1111913	1111913	1111910
SECTION B: EXPENSES							
PERSONAL SERVICES							
16)	Personal Services-Program/Site & Program Admin*	11999	153,488	154,807	24,510	21,623	18,656
17)	Vacation Accruals-Program/Site & Program Admin*	12999	3,023	3,022	101	101	858
FRINGE BENEFITS							
18)	Mandated Fringe Benefits	13200	13,874	13,873	3,577	3,577	1,691
19)	Non-Mandated Fringe Benefits	13300	16,956	16,956	2,668	2,668	2,074
20)	Total Fringe Benefits (Sum Lines 18 & 19)	13999	30,830	30,829	6,245	6,245	3,765
OTHER THAN PERSONAL SERVICES (OTPS)							
21)	Food	14010	400	400	0	0	0
22)	Repairs and Maintenance	14020	60	60	107	106	131
23)	Utilities	14030	1,250	1,250	0	0	355
24)	Transportation Related - Participant**	14040	188	187	2	0	53
25)	Staff Travel	14250	125	125	7	8	31
26)	Participant Incidentals	14050	286	286	0	0	59
27)	Expensed Adaptive Equipment (OMRDD and SED only)	14070	0	0	0	0	0
28)	Expensed Equipment	14080	466	465	0	0	132
29)	Sub-Contract Raw Materials	14090	0	0	0	0	0
30)	Participant Wages - Non-Contract	14100	0	0	0	0	0

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 AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 SCHOOL CODE: 010205005555  
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Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3	4	5
	Program Code (Program Code Index)		9100 (FF)	9100 (SS)	9135 (FF)	9135 (SS)	9190 (FF)
	Program/Site Identification Number		1111910	1111910	1111913	1111913	1111910
31)	Participant Wages-Contract	14110	0	0	0	0	0
32)	Participant Fringe Benefits	14120	0	0	0	0	0
33)	Section 43.04 Services Assessment (OMRDD only)	14130	0	0	0	0	0
34)	Staff Development	14140	287	287	0	0	87
35)	Contracted Direct Care and Clinical Personal Services (from CFR-4A)	14150	2,625	2,625	0	0	745
36)	Supplies and Materials - Non-Household	14160	1,715	1,715	0	0	495
37)	Household Supplies	14170	140	140	0	0	39
38)	Telephone	14190	578	577	395	396	159
39)	Insurance - General	14260	450	450	0	0	128
40)	Other (Detail Required)	14998	275	275	16	16	78
41)	Total Other Than Personal Services (Sum Lines 21-40)	14999	8,845	8,842	527	526	2,492
EQUIPMENT - PROVIDER PAID							
42)	Lease/Rental Vehicle	15010	51	51	0	0	14
43)	Lease/Rental Equipment	15020	188	187	0	0	53
44)	Depreciation - Vehicle	15040	313	312	0	0	89
45)	Depreciation - Equipment	15050	339	338	15	15	96
46)	Interest - Vehicle	15070	125	125	0	0	8
47)	Other (Detail Required)	15998	475	475	0	0	135
48)	Total Equipment (Sum Lines 42-47)	15999	1,491	1,488	15	15	395
PROPERTY - PROVIDER PAID							
49)	Lease/Rental - Real Property	16010	10,500	10,500	519	519	2,980
50)	Leasehold/Leasehold Improvements	16020	125	125	0	0	71
51)	Depreciation - Building	16030	1,500	1,500	0	0	425
52)	Depreciation - Building/Land Improvements	16040	540	540	0	0	153

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AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
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Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3	4	5
	Program Code (Program Code Index)		9100 (FF)	9100 (SS)	9135 (FF)	9135 (SS)	9190 (FF)
	Program/Site Identification Number		1111910	1111910	1111913	1111913	1111910
53)	Mortgage/Cap Imprv Interest (Report MCFFA Bond Int. on Line 59)	16060	194	194	0	0	55
54)	Mortgage Expenses	16070	0	0	0	0	8
55)	Insurance - Property & Casualty	16080	145	145	99	99	35
56)	Real Estate Taxes	16090	125	125	0	0	145
57)	Interest on Capital Indebtedness	16100	510	510	0	0	148
58)	Start-Up Expenses	16110	522	522	0	0	14
59)	MCFFA/DASNY Interest Expense	16120	50	50	0	0	0
60)	MCFFA/DASNY Administration Fees	16130	0	0	0	0	0
61)	Maintenance in Lieu of Rent (LGU Only)	16140	0	0	0	0	0
62)	Other (Detail Required)	16998	346	346	0	0	198
63)	Total Property-Provider Paid (Sum of Lines 49-62)	16999	14,557	14,557	618	618	4,232
TOTALS							
64)	Total Operating Costs (Sum lines 16,17,20,41 minus 29)	19010	196,186	197,500	31,383	28,495	25,771
65)	Agency Admin. Alloc.* (Line 64 times 0.097691)	19050	19,166	19,293	3,066	2,784	2,518
66)	Adjustments/Non-Allowable Costs (Detail Required)	19030	324	0	0	0	0
67)	Total Prog/Site Costs (Sum lines 29, 48, 63-65 minus 66)	19060	231,076	232,838	35,082	31,912	32,916
OMRDD Only - Informational							
68a)	Other Than To/From Transportation Allocation	19101	0	0	0	0	0
68b)	To/From Transportation Allocation	19102	0	0	0	0	0
68c)	ICF/DD SED Contract Liability	19103	0	0	0	0	0
68d)	ICF/DD Day Services Liability	19104	0	0	0	0	0

\* 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.

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AGENCY NAME: Any Agency Inc.  
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 SCHOOL CODE: 010205005555

Line No.	COLUMN NUMBER ITEM DESCRIPTION Program Code (Program Code Index) Program/Site Identification Number	Cost Codes	1 9100 (FF) 1111910	2 9100 (SS) 1111910	3 9135 (FF) 1111913	4 9135 (SS) 1111913	5 9190 (FF) 1111910
SECTION C: REVENUES							
69)	Participant Fee (Less SSI & SSA)	20010	0	0	0	0	0
70)	SSI and SSA	20020	0	0	0	0	0
71)	Home Relief/Public Assistance	20030	0	0	0	0	0
72)	Medicaid	20040	0	0	0	0	0
73)	Medicare	20060	0	0	0	0	0
74)	Other Third Parties (Detail Required)	20070	0	0	0	0	0
75)	OMRDD Residential Room and Board/NYS OPTS	20080	0	0	0	0	0
76)	Transportation, Medicaid	20090	0	0	0	0	0
77)	Transportation, Other (Detail Required)	20100	0	0	0	0	0
78)	Sales: Contract Total	21070	0	0	0	0	0
79)	Federal Grants (Detail Required)	22040	0	0	0	0	0
80)	State Grants (Detail Required)	22030	0	0	0	0	0
81)	LTSE Income Total (OMH and OMRDD only)	22080	0	0	0	0	0
82)	Food Stamps (OASAS, OMRDD), Food Revenue (SED Only)	22160	0	0	0	0	0
83)	Gifts, Legacies, Bequests, Restricted Donations	22010	50	50	0	0	0
84)	Section 202/8/811 HUD Funds *	22020	0	0	0	0	0
85)	Interest/Dividend Income	22050	200	200	0	0	71
86)	Prior Period Rate Adjustments**	22090	2,503	2,502	0	0	696
87)	Excessive Teacher Turnover Prevention Grant (SED only)	22100	0	0	0	0	0
88)	LDSS County Revenue (SED only)	22110	0	0	0	0	0
89)	4402 Revenue (School District In-State)(SED only)	22120	0	0	0	0	0

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

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 AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
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Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3	4	5
	Program Code (Program Code Index)		9100 (FF)	9100 (SS)	9135 (FF)	9135 (SS)	9190 (FF)
	Program/Site Identification Number		1111910	1111910	1111913	1111913	1111910
90)	Department of Health Chapter 428 Revenue (SED only)	22130	0	0	0	0	0
91)	4408 Revenue (School District)(SED only)	22140	0	0	0	0	0
92)	4410 Revenue (Preschool) (SED only)	22150	192,617	192,616	30,978	30,977	34,612
93)	Net Deficit Funding (State & LGU Funding only)*	20110	0	0	0	0	0
94)	Other (Detail Required)	22998	12	13	0	0	9
95)	Gross Revenues (Sum Lines 69-94)	23999	195,382	195,381	30,978	30,977	35,388
GAAP ADJUSTMENTS TO REVENUE							
96)	Participant Allowance	24010	0	0	0	0	0
97)	Uncollectible Accounts Receivable	24040	0	0	0	0	0
98)	Other (Detail Required)	24996	0	0	0	0	0
99)	Total GAAP Adjustments (Sum Lines 96-98)	24997	0	0	0	0	0
100)	Net GAAP Revenues (Line 95 minus 99)	24998	195,382	195,381	30,978	30,977	35,388
NON-GAAP ADJUSTMENTS TO REVENUE							
101)	Exempt Contract Income	24050	0	0	0	0	0
102)	Exempt LTSE Income	24060	0	0	0	0	0
103)	Net Deficit Funding**	24070	0	0	0	0	0
104)	Other (Detail Required)	24080	0	0	0	0	0
105)	Total NON-GAAP Adjustments (Sum Lines 101-104)	24097	0	0	0	0	0
106)	TOTAL ADJ. TO REVENUE (Sum Lines 99 & 105)	24999	0	0	0	0	0
107)	TOTAL NET REVENUES (Line 95 minus 106)	25999	195,382	195,381	30,978	30,977	35,388

\* Do not include non-funded or voluntary contributions.

\*\* Amounts should equal the corresponding amounts reported as revenue on line 93 above.

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Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	6	7	8
SECTION A: GENERAL INFORMATION					
1)	Program Type	00070	Preschool-Evaluations	Federal Grants (611)	Federal Grants (611)
2)	Program Code (Program Code Index)	00010	9190 (SS)	9805 (FF)	9805 (SS)
3)	Program/Site Identification Number	00050	1111910	1111980	1111980
4)	Program/Site Name	00020	Preschool Evauations	611 Grants	611 Grants
5)	Program/Site Address (Line One)	00030	53 Bunn St	2 Spruce St.	2 Spruce St.
6)	Program/Site Address (Line Two)	00040	Syracuse, NY 13210-2330	Syracuse, NY 13211-2210	Syracuse, NY 13211-2210
7)	Medicaid Provider Agreement Number (DMH only)	00060			
8)	County Code (See Appendix C)	00080	34	34	34
9)	Date Site Opened	00090			
10)	Certified Capacity (OASAS, OMRDD and SED only)	00100	0	0	0
11)	Actual Capacity (OMH, OMRDD and SED only)	00110	0	0	0
12)	Actual Days Program/Site Open	00160	0	0	0
13)	Units Of Service	00120	132	0	0
14)	Respite or TUBS Units of Service (OMRDD only)	00130	0	0	0
15)	Program/Site Square Footage (OASAS, OMRDD and SED Only)	00150	0	0	0

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Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	6	7	8
	Program Code (Program Code Index)		9190 (SS)	9805 (FF)	9805 (SS)
	Program/Site Identification Number		1111910	1111980	1111980
SECTION B: EXPENSES					
PERSONAL SERVICES					
16)	Personal Services-Program/Site & Program Admin*	11999	18,658	0	0
17)	Vacation Accruals-Program/Site & Program Admin*	12999	858	0	0
FRINGE BENEFITS					
18)	Mandated Fringe Benefits	13200	1,690	0	0
19)	Non-Mandated Fringe Benefits	13300	2,073	0	0
20)	Total Fringe Benefits (Sum Lines 18 & 19)	13999	3,763	0	0
OTHER THAN PERSONAL SERVICES (OTPS)					
21)	Food	14010	0	0	0
22)	Repairs and Maintenance	14020	130	0	0
23)	Utilities	14030	355	0	0
24)	Transportation Related - Participant**	14040	53	0	0
25)	Staff Travel	14250	31	0	0
26)	Participant Incidentals	14050	59	0	0
27)	Expensed Adaptive Equipment (OMRDD and SED only)	14070	0	0	0
28)	Expensed Equipment	14080	132	0	0
29)	Sub-Contract Raw Materials	14090	0	0	0
30)	Participant Wages - Non-Contract	14100	0	0	0

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Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	6 9190 (SS) 1111910	7 9805 (FF) 1111980	8 9805 (SS) 1111980
31)	Participant Wages-Contract	14110	0	0	0
32)	Participant Fringe Benefits	14120	0	0	0
33)	Section 43.04 Services Assessment (OMRDD only)	14130	0	0	0
34)	Staff Development	14140	87	0	0
35)	Contracted Direct Care and Clinical Personal Services (from CFR-4A)	14150	745	0	0
36)	Supplies and Materials - Non-Household	14160	485	0	0
37)	Household Supplies	14170	40	0	0
38)	Telephone	14190	160	0	0
39)	Insurance - General	14260	128	0	0
40)	Other (Detail Required)	14998	75	0	0
41)	Total Other Than Personal Services (Sum Lines 21-40)	14999	2,480	0	0
EQUIPMENT - PROVIDER PAID					
42)	Lease/Rental Vehicle	15010	15	0	0
43)	Lease/Rental Equipment	15020	53	750	750
44)	Depreciation - Vehicle	15040	88	0	0
45)	Depreciation - Equipment	15050	96	0	0
46)	Interest - Vehicle	15070	8	0	0
47)	Other (Detail Required)	15998	135	0	0
48)	Total Equipment (Sum Lines 42-47)	15999	395	750	750
PROPERTY - PROVIDER PAID					
49)	Lease/Rental - Real Property	16010	2,980	0	0
50)	Leasehold/Leasehold Improvements	16020	71	0	0
51)	Depreciation - Building	16030	427	0	0
52)	Depreciation - Building/Land Improvements	16040	153	0	0

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 AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
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Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	6	7	8
	Program Code (Program Code Index)		9190 (SS)	9805 (FF)	9805 (SS)
	Program/Site Identification Number		1111910	1111980	1111980
53)	Mortgage/Cap Imprv Interest (Report MCFFA Bond Int. on Line 59)	16060	55	0	0
54)	Mortgage Expenses	16070	9	0	0
55)	Insurance - Property & Casualty	16080	36	0	0
56)	Real Estate Taxes	16090	144	0	0
57)	Interest on Capital Indebtedness	16100	148	0	0
58)	Start-Up Expenses	16110	14	0	0
59)	MCFFA/DASNY Interest Expense	16120	0	0	0
60)	MCFFA/DASNY Administration Fees	16130	0	0	0
61)	Maintenance in Lieu of Rent (LGU Only)	16140	0	0	0
62)	Other (Detail Required)	16998	198	0	0
63)	Total Property-Provider Paid (Sum of Lines 49-62)	16999	4,235	0	0
TOTALS					
64)	Total Operating Costs (Sum lines 16,17,20,41 minus 29)	19010	25,759	0	0
65)	Agency Admin. Alloc.* (Line 64 times 0.097691)	19050	2,516	0	0
66)	Adjustments/Non-Allowable Costs (Detail Required)	19030	0	0	0
67)	Total Prog/Site Costs (Sum lines 29, 48, 63-65 minus 66)	19060	32,905	750	750
OMRDD Only - Informational					
68a)	Other Than To/From Transportation Allocation	19101	0	0	0
68b)	To/From Transportation Allocation	19102	0	0	0
68c)	ICF/DD SED Contract Liability	19103	0	0	0
68d)	ICF/DD Day Services Liability	19104	0	0	0

\* 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.

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AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 SCHOOL CODE: 010205005555

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	6	7	8
	Program Code (Program Code Index)		9190 (SS)	9805 (FF)	9805 (SS)
	Program/Site Identification Number		1111910	1111980	1111980
SECTION C: REVENUES					
69)	Participant Fee (Less SSI & SSA)	20010	0	0	0
70)	SSI and SSA	20020	0	0	0
71)	Home Relief/Public Assistance	20030	0	0	0
72)	Medicaid	20040	0	0	0
73)	Medicare	20060	0	0	0
74)	Other Third Parties (Detail Required)	20070	0	0	0
75)	OMRDD Residential Room and Board/NYS OPTS	20080	0	0	0
76)	Transportation, Medicaid	20090	0	0	0
77)	Transportation, Other (Detail Required)	20100	0	0	0
78)	Sales: Contract Total	21070	0	0	0
79)	Federal Grants (Detail Required)	22040	0	0	0
80)	State Grants (Detail Required)	22030	0	0	0
81)	LTSE Income Total (OMH and OMRDD only)	22080	0	0	0
82)	Food Stamps (OASAS, OMRDD), Food Revenue (SED Only)	22160	0	0	0
83)	Gifts, Legacies, Bequests, Restricted Donations	22010	0	0	0
84)	Section 202/8/811 HUD Funds *	22020	0	0	0
85)	Interest/Dividend Income	22050	72	0	0
86)	Prior Period Rate Adjustments**	22090	697	0	0
87)	Excessive Teacher Turnover Prevention Grant (SED only)	22100	0	0	0
88)	LDSS County Revenue (SED only)	22110	0	0	0
89)	4402 Revenue (School District In-State)(SED only)	22120	0	0	0

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

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 AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 SCHOOL CODE: 010205005555  
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Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	6	7	8
	Program Code (Program Code Index)		9190 (SS)	9805 (FF)	9805 (SS)
	Program/Site Identification Number		1111910	1111980	1111980
90)	Department of Health Chapter 428 Revenue (SED only)	22130	0	0	0
91)	4408 Revenue (School District)(SED only)	22140	0	0	0
92)	4410 Revenue (Preschool) (SED only)	22150	34,612	0	0
93)	Net Deficit Funding (State & LGU Funding only)*	20110	0	0	0
94)	Other (Detail Required)	22998	0	750	750
95)	Gross Revenues (Sum Lines 69-94)	23999	35,381	750	750
GAAP ADJUSTMENTS TO REVENUE					
96)	Participant Allowance	24010	0	0	0
97)	Uncollectible Accounts Receivable	24040	0	0	0
98)	Other (Detail Required)	24996	0	0	0
99)	Total GAAP Adjustments (Sum Lines 96-98)	24997	0	0	0
100)	Net GAAP Revenues (Line 95 minus 99)	24998	35,381	750	750
NON-GAAP ADJUSTMENTS TO REVENUE					
101)	Exempt Contract Income	24050	0	0	0
102)	Exempt LTSE Income	24060	0	0	0
103)	Net Deficit Funding**	24070	0	0	0
104)	Other (Detail Required)	24080	0	0	0
105)	Total NON-GAAP Adjustments (Sum Lines 101-104)	24097	0	0	0
106)	TOTAL ADJ. TO REVENUE (Sum Lines 99 & 105)	24999	0	0	0
107)	TOTAL NET REVENUES (Line 95 minus 106)	25999	35,381	750	750

\* Do not include non-funded or voluntary contributions.

\*\* Amounts should equal the corresponding amounts reported as revenue on line 93 above.

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SCHEDULE CFR-2  
AGENCY FISCAL  
SUMMARY

AGENCY NAME: Any Agency Inc.  
AGENCY CODE: 11110  
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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	Cost Codes	1 AGENCY TOTALS (Sum Col. 2-7)	2 OASAS TOTALS	3 OMH TOTALS	4 OMRDD TOTALS	5 SED TOTALS	6 SHARED PRG. TOTALS	7 OTHER PROGRAMS TOTALS*
EXPENSES									
1)	Personal Services (CFR-1, Line 16)	31999	4,236,953	0	1,095,844	0	391,742	0	2,749,367
2)	Vacation Leave Accruals (CFR-1, Line 17)	32999	10,971	0	2,842	0	7,963	0	166
3)	Fringe Benefits (CFR-1, Line 20)	33999	1,219,577	0	224,624	0	81,677	0	913,276
4)	OTPS (CFR-1, Line 41)	34999	1,671,884	0	246,163	0	23,712	0	1,402,009
5)	Equipment-Provider Paid (CFR-1, Line 48)	35999	230,473	0	1,515	0	5,299	0	223,659
6)	Property-Provider Paid (CFR-1, Line 63)	36999	923,147	0	108,743	0	38,817	0	775,587
7)	Net Agency Admin. (CFR-1, Line 65)	38050	697,456	0	153,324	0	49,343	0	494,789
8)	Adj./Non-Allow. Costs (CFR-1, Line 66)	38030	824	0	0	0	324	0	500
9)	Total Adj. Expenses (Sum Lines 1-7 minus 8)	38999	8,989,637	0	1,833,055	0	598,229	0	6,558,353
REVENUES									
10)	Gross Revenues (CFR-1, Line 95)	40999	9,349,602	0	1,836,270	0	524,987	0	6,988,345
11)	GAAP Adj. to Revenue (CFR-1, Line 99)	43999	0	0	0	0	0	0	0
12)	Net GAAP Revenues (Line 10 minus Line 11)	44999	9,349,602	0	1,836,270	0	524,987	0	6,988,345

\* 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: January 1, 2009 TO December 31, 2009

SCHEDULE CFR-3  
 AGENCY  
 ADMINISTRATION

-----  
 AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 SCHOOL CODE: 010205005555  
 -----

Line No.	ITEM DESCRIPTION	Cost Codes	AGENCY ADMIN TOTALS	Line No.	ITEM DESCRIPTION	Cost Codes	AGENCY ADMIN TOTALS
	PERSONAL SERVICES			21)	Depreciation - Vehicle	15041	2,330
1)	Total Personal Services (from CFR-4, Agency Admin.)	11998	379,487	22)	Depreciation - Equipment	15060	4,754
2)	Vacation Leave Accruals	12998	12,513	23)	Interest - Vehicle	15071	1,258
	FRINGE BENEFITS			24)	Other (Detail Required)	15997	0
3)	Mandated Fringe Benefits	13201	35,886	25)	Total Equipment (Sum Lines 19-24)	15996	16,339
4)	Non-Mandated Fringe Benefits	13301	38,784		PROPERTY - PROVIDER PAID		
5)	Total Fringe Benefits (Sum Lines 3-4)	13998	74,670	26)	Lease/Rental - Real Property	16011	50,726
	OTHER THAN PERSONAL SERVICES (OTPS)			27)	Leasehold/Leasehold Improvements	16021	0
6)	Audit/Legal	14200	25,935	28)	Depreciation - Building	16031	0
7)	Utilities	14210	18,931	29)	Depreciation - Building/Land Improvements	16050	0
8)	Telephone	14220	13,725	30)	Mortgage Interest	16061	0
9)	Repairs and Maintenance	14021	18,685	31)	Mortgage Expenses	16071	0
10)	Office Supplies and Postage	14161	24,971	32)	Insurance - Property & Casualty	16081	15,643
11)	Organizational Expense	14230	0	33)	Real Estate Taxes	16091	0
12)	Interest - Working Capital	14240	844	34)	Maintenance in Lieu of Rent (LGU only)	16141	0
13)	Expensed Equipment	14081	1,590	35)	Interest on Capital Indebtedness	16101	0
14)	Contracted Personal Services	14151	23,510	36)	Other (Detail Required)	16997	0
15)	Staff Travel	14251	13,400	37)	Total Property (Sum Lines 26-36)	16996	66,369
16)	Insurance - General	14261	4,900		-----		
17)	Other (Detail Required)	14997	1,587	38)	Parent Agency Administration Allocation	19070	0
18)	Total OTPS (Sum Lines 6-17)	14996	148,078	39)	County Wide Cost Allocation (LGU Only)	19080	0
	EQUIPMENT - PROVIDER PAID			40)	Total Agency Administration (Sum Lines 1,2,5,18,25,37,38,39)	19090	697,456
19)	Lease/Rental - Vehicle	15011	5,297	41)	Adjustments/Non-Allowable Costs (Detail Required)	19031	0
20)	Lease/Rental - Equipment	15030	2,700	42)	Net Agency Administration (Line 40 minus 41)	19998	697,456

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: January 1, 2009 TO December 31, 2009

SCHEDULE CFR-3  
AGENCY  
ADMINISTRATION

-----  
AGENCY NAME: Any Agency Inc.  
AGENCY CODE: 11110  
SCHOOL CODE: 010205005555  
-----

RATIO VALUE WORKSHEET (AGENCY-WIDE)				ADJUSTED RATIO VALUE WORKSHEET (WITHIN STATE AGENCY)			
Line No.	State Agency	Cost Codes	Amount	Line No.	State Agency	Cost Codes	Amount
CALCULATION OF OPERATING COSTS *				CALCULATION OF ADJUSTED OPERATING COSTS ****			
43)	OASAS Subtotal	19110	0	60)	OASAS Adjusted Subtotal	19310	0
44)	OMH Subtotal	19120	1,569,473	61)	OMH Adjusted Subtotal	19320	1,569,473
45)	OMRDD Subtotal	19130	0	62)	OMRDD Adjusted Subtotal	19330	0
46)	SED Subtotal	19140	505,094	63)	SED Adjusted Subtotal	19340	505,094
47)	Shared Programs Subtotal	19150	0	64)	Shared Programs Adjusted Subtotal	19350	0
48)	Other Programs Subtotal**	19160	5,064,818				
49)	Total Agency Operating Costs	19170	7,139,385				
CALCULATION OF RATIO VALUE FACTOR				CALCULATION OF ADJUSTED RATIO VALUE FACTOR *****			
50)	Net Agency Administration (CFR-3, Line 42)	19999	697,456	65)	OASAS Ratio Value Factor (line 53 divided by line 60)	19410	0.000000
51)	Total Agency Operating Costs (CFR-3, Line 49)	19171	7,139,385	66)	OMH Ratio Value Factor (line 54 divided by line 61)	19420	0.097691
52)	Ratio Value Factor (Line 50 divided by Line 51)	19180	0.097691	67)	OMRDD Ratio Value Factor (line 55 divided by line 62)	19430	0.000000
				68)	SED Ratio Value Factor (line 56 divided by line 63)	19440	0.097691
				69)	Shared Programs Ratio Value Factor (line 57 divided by line 64)	19450	0.000000
ALLOCATION OF AGENCY ADMINISTRATION USING RATIO VALUE ***							
53)	OASAS Allocation (line 43 x line 52)	19210	0				
54)	OMH Allocation (line 44 x line 52)	19220	153,324				
55)	OMRDD Allocation (line 45 x line 52)	19230	0				
56)	SED Allocation (line 46 x line 52)	19240	49,343				
57)	Shared Programs Allocation (line 47 x line 52)	19250	0				
58)	Other Programs Allocation (line 48 x line 52)	19260	494,789				
59)	Total Agency Administration (sum lines 53 - 58)	19270	697,456				

\* 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 cost 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 (line 62), do not include operating costs for programs 2091 and 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: January 1, 2009 TO December 31, 2009

SCHEDULE CFR-4  
 PERSONAL  
 SERVICES

AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 SCHOOL CODE: 010205005555

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) [ X ] \*

COLUMN NUMBER		1																
PROGRAM CODE ** (PROGRAM CODE INDEX)		ADMINISTRATION																
PROGRAM/SITE IDENTIFICATION NUMBER **																		
PROGRAM/SITE NAME																		
Position	PROGRAM/SITE ADDRESS (Line One)																	
Title	PROGRAM/SITE ADDRESS (Line Two)																	
Code	COUNTY CODE																	
Appendix		Standard	Hours	Amount	Hours	Amount	Hours	Amount	Hours	Amount	Hours	Amount	Hours	Amount	Hours	Amount	Hours	Amount
R	Position Title	35	37.5	40	Other	Paid	FTE	Paid	Paid	FTE	Paid	Paid	FTE	Paid	Paid	FTE	Paid	Paid
	601 Executive Director/Chief E		X			2,080	1.000	110,014										
	603 Comptroller/Controller		X			2,080	1.000	78,216										
	605 Office Worker		X			6,448	3.100	77,002										
	609 Computer/Data/Statistical		X			2,080	1.000	42,500										
	610 Community Relations		X			1,040	0.500	23,817										
	690 Other Agency Administratio		X			3,120	1.500	47,938										

Total "Hours Paid", "FTE" and "Amount Paid" for Positions.      16,848      8.100      379,487

\* 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: January 1, 2009 TO December 31, 2009

SCHEDULE CFR-4  
 PERSONAL  
 SERVICES

AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 SCHOOL CODE: 010205005555

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	Appendix Code	COLUMN NUMBER	1			2			3			4			5																		
			PROGRAM CODE ** (PROGRAM CODE INDEX)	PROGRAM/SITE IDENTIFICATION NUMBER **	PROGRAM/SITE NAME	Center (over 2.5 hrs)	Hours Paid	FTE	Amount Paid	Center (over 2.5 hrs)	Hours Paid	FTE	Amount Paid	Pre. Sch. Spec. Ed. Itinerant	Hours Paid	FTE	Amount Paid	Pre. Sch. Spec. Ed. Itinerant	Hours Paid	FTE	Amount Paid	Preschool Evaluations	Hours Paid	FTE	Amount Paid								
218 Teacher - Special Educati	X	35	9100 (FF)	1111910	Center (over 2.5 hrs)	4,050	2.225	100,700	9100 (SS)	1111910	Center (over 2.5 hrs)	4,000	2.198	102,850	9135 (FF)	1111913	Pre. Sch. Spec. Ed. Itinerant	942	0.518	21,806	9135 (SS)	1111913	Pre. Sch. Spec. Ed. Itinerant	819	0.450	18,934	9190 (FF)	1111910	Preschool Evaluations	224	0.123	3,793	
236 Guidance Counselor	X		53 Bunn St	Syracuse, New York 13210-2330	34				53 Bunn St	Syracuse, New York 13210-2330	34			50 Valley Dr.	Syracuse, New York 13210-2105	34					50 Valley Dr.	Syracuse, New York 13210-2105	34			53 Bunn St	Syracuse, New York 13210-2330	34					
333 Therapist - Occupational			X			44	0.023	832																									
334 Therapist - Physical			X			877	0.450	22,083																									
335 Therapist - Speech			X			958	0.491	20,000																									
501 Program or Site Director				X		453	0.218	9,873																									
505 Office Worker	X																																
Total "Hours Paid", "FTE" and "Amount Paid" for Positions.						6,382	3.407	153,488	6,288	3.357	154,807	1,088	0.598	24,510	955	0.525	21,623	884	0.457	18,656													

\* 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: January 1, 2009 TO December 31, 2009

SCHEDULE CFR-4  
 PERSONAL  
 SERVICES

AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 SCHOOL CODE: 010205005555

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)  \*

Column Number	6	7	8										
PROGRAM CODE ** (PROGRAM CODE INDEX)	9190 (SS)	9805 (FF)	9805 (SS)										
PROGRAM/SITE IDENTIFICATION NUMBER **	1111910	1111980	1111980										
PROGRAM/SITE NAME	Preschool Evaluations	611 Grants	611 Grants										
Position PROGRAM/SITE ADDRESS (Line One)	53 Bunn St	2 Spruce St.	2 Spruce St.										
Title PROGRAM/SITE ADDRESS (Line Two)	Syracuse, New York 13210-2330	Syracuse, New York 13211-2210	Syracuse, New York 13211-2210										
Code COUNTY CODE	34	34	34										
Appendix	Standard Work Week	Hours Paid	FTE	Amount Paid	Hours Paid	FTE	Amount Paid	Hours Paid	FTE	Amount Paid	Hours Paid	FTE	Amount Paid
R	35   37.5   40   Other												
218 Teacher - Special Educati	X												
236 Guidance Counselor	X			224	0.123	3,793							
333 Therapist - Occupational		X		6	0.003	118							
334 Therapist - Physical		X		249	0.128	6,268							
335 Therapist - Speech		X		272	0.139	5,677							
501 Program or Site Director			X	124	0.060	2,802							
505 Office Worker	X												

Total "Hours Paid", "FTE" and "Amount Paid" for Positions. 875 0.453 18,658 0 0.000 0 0 0.000 0

\* 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 [ X ] SED  
 [ ] OMRDD  
 [ ] OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: January 1, 2009 TO December 31, 2009

SCHEDULE CFR-4A  
 CONTRACTED DIRECT  
 CARE AND CLINICAL  
 PERSONAL SERVICES  
 PAGE 31

AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 SCHOOL CODE: 010205005555

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	1		2		3		4		5	
	Hours Paid	Amount Paid	Hours Paid	Amount Paid	Hours Paid	Amount Paid	Hours Paid	Amount Paid	Hours Paid	Amount Paid
224 Teacher - Substitute	20	1,625	20	1,625						
318 Psychiatrist									1	245
321 Psychologist (Licensed)									5	300
322 Psychologist (Master's Level)/Behavioral Specialis									5	200
335 Therapist - Speech	15	1,000	15	1,000						
<b>Total "Hours Paid" and "Amount Paid" for Positions.</b>	<b>35</b>	<b>2,625</b>	<b>35</b>	<b>2,625</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>11</b>	<b>745</b>

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

Funding State Agency:  
 OMH     SED  
 OMRDD  
 OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: January 1, 2009 TO December 31, 2009

AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 SCHOOL CODE: 010205005555

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	PROGRAM/SITE ADDRESS (Line One) PROGRAM/SITE ADDRESS (Line Two) COUNTY CODE	6		7		8		Hours Paid	Amount Paid	Hours Paid	Amount Paid
		PROGRAM CODE (PROGRAM CODE INDEX)	PROGRAM/SITE IDENTIFICATION NUMBER	PROGRAM/SITE NAME	PROGRAM/SITE ADDRESS (Line One) PROGRAM/SITE ADDRESS (Line Two) COUNTY CODE	PROGRAM CODE (PROGRAM CODE INDEX)	PROGRAM/SITE IDENTIFICATION NUMBER				
224 Teacher - Substitute											
318 Psychiatrist											
321 Psychologist (Licensed)		1	245								
322 Psychologist (Master's Level)/Behavioral Specialis		5	300								
335 Therapist - Speech		5	200								
Total "Hours Paid" and "Amount Paid" for Positions.		11	745	0	0	0	0				

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

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: January 1, 2009 TO December 31, 2009

AGENCY NAME: Any Agency Inc. AGENCY CODE: 11110 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 [X] 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 Line No.	2 Item No.	3 PROGRAM/SITES AFFECTED ENTER PROG/SITE ID# (CODE) OR ADMINISTRATION	4 DESCRIPTION OF TRANSACTION	5 NAME OF RELATED ORGANIZATION/INDIVIDUAL	6 RELATIONSHIP TO PROVIDER*	7 AMOUNT OF TRANSACTION REPORTED	8 ALLOWABLE COSTS	9 ADJUSTMENTS TO COSTS (COL.7 MINUS 8)
1.	1	1310 (00)/1111052	leased space	Any Agency Foundation	G	68,620	68,620	0

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 Line No.	2 Item No.	3 PROGRAM/SITES AFFECTED ENTER PROG/SITE ID# (CODE) OR ADMIN.	4 DEPRECIATION	5 MORTGAGE INTEREST	6 INSURANCE	7 PROPERTY TAXES	8 OTHER (SPECIFY)	9 TOTAL ALLOWABLE COSTS
1.	1	1310 (00)/1111052	41,620	15,000	5,500	6,500	0	68,620

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 Line No.	2 Item No.	3 Name of Related Party/Individual	4 Street Address	5 City, State	6 Type of Financial Support/Aid	7 Funding To/From	8 Funding To/From Amount
---------------	---------------	--	---------------------	------------------	---------------------------------------	-------------------------	--------------------------------

NO DATA WAS FOUND FOR THIS SECTION

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

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: January 1, 2009 TO December 31, 2009

SCHEDULE CFR-6  
GOVERNING BOARD AND  
COMPENSATION SUMMARY

-----  
AGENCY NAME: Any Agency Inc.  
AGENCY CODE: 11110  
SCHOOL CODE: (SED ONLY)  
-----

MEMBERS OF THE GOVERNING AUTHORITY

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.

COMPENSATION OF BOARD OFFICERS, BOARD OF DIRECTORS, AND BOARD TRUSTEES

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
------	-------------	---------------------------	-----------------	------------------	--------------------

NO DATA WAS FOUND FOR THIS SECTION

COMPENSATION OF THE FIVE HIGHEST PAID EMPLOYEES AND INDEPENDENT CONTRACTORS

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 amount (column 7) is in excess of \$125,000 per year:

[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]
NAME	POSITION TITLE	AMOUNT PAID	FTE	ANNUALIZED SALARY	CONTRACTED PAYMENT AMOUNT	TOTAL ANNUALIZED SALARY AND CONTRACTED PAYMENT	FRINGE BENEFITS	OTHER BENEFITS**
1. Marcus Welby	318	135,005	1.000	135,005	135,005	135,005	33,750	0
2. Mary Reynolds	601	110,014	1.000	110,014	110,014	110,014	27,503	1,200
3. Gregory House	501 X	100,000	1.000	100,000	100,000	100,000	25,001	0
4. Lewis Knoxberry	603	78,216	1.000	78,216	78,216	78,216	19,554	0
5. Sam Malone	317 X	55,000	0.880	62,500	62,500	62,500	15,001	0

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

[1]	[2]	[3]
NAME	TYPE OF SERVICE	AMOUNT PAID
1. Ed Norton MD	Medical	58,885

5. Number of additional employees and independent contractors whose annualized salary and/or contracted payment amount is in excess of \$50,000: 3

\* 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)

Funding State Agency:  
 OMH  
 OMRDD  
 OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: January 1, 2009 TO December 31, 2009

SCHEDULE DMH-1  
 PROGRAM FISCAL  
 SUMMARY

AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3
1) Program Type		00071	Continuing Day Treatm	Advocacy/Support Serv	Community Residence,
2) Program Code (Program Code Index)		00011	1310 (00)	1760 (00)	7050 (00)
UNITS OF SERVICE					
3) OMH Units of Service		00121	19,005	1,699	2,628
4) OMRDD Units of Service		00161	0	0	0
5) OASAS Units of Service		00170	0	0	0
EXPENSES *					
6) Personal Services		17010	471,265	45,981	578,598
7) Vacation Leave Accruals		17020	685	845	1,312
8) Fringe Benefits		17030	94,200	8,617	121,807
9) Other Than Personal Services		17040	165,008	6,668	74,487
10) Equipment - Provider Paid		17050	0	294	1,221
11) Property - Provider Paid		17060	68,620	2,810	37,313
12) Agency Administration		17080	71,428	6,068	75,828
13) Adjustments/Non-Allowable Costs		17090	0	0	0
14) Total Adjusted Expenses (Lines 6-12 Minus 13)		17999	871,206	71,283	890,566
REVENUES *					
15) Participant Fees (less SSI and SSA)		26010	0	0	0
16) SSI and SSA		26020	0	0	69,505
17) Home Relief/Public Assistance		26030	0	0	0
18) Medicaid		26040	935,128	0	816,070
19) Medicare		26060	0	0	0
20) Other Third Parties		26070	1,278	0	0
21) OMRDD Residential Room and Board/NYS OPTS		26080	0	0	0
22) Transportation, Medicaid		26090	0	0	0
23) Transportation, Other		26100	0	0	0
24) Sales: Contract Total		26140	0	0	0
25) Federal Grants (Detail Required)		26160	0	0	0

\* These amounts are the program type totals for all program/sites aggregated from Schedule CFR-1. This does not apply to agencies filing abbreviated CFR forms.

Funding State Agency:

[ X ] OMH  
[ ] OMRDD  
[ ] OASAS

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: January 1, 2009 TO December 31, 2009

SCHEDULE DMH-1  
PROGRAM FISCAL  
SUMMARY

AGENCY NAME: Any Agency Inc.  
AGENCY CODE: 11110

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3
	Program Type	00071	Continuing Day Treatm	Advocacy/Support Serv	Community Residence,
	Program Code (Program Code Index)	00011	1310 (00)	1760 (00)	7050 (00)
26)	State Grants (Detail Required)	26190	0	0	0
27)	LTSE Income Total (OMH and OMRDD only)	26220	0	0	0
28)	Food Stamps (OASAS Only)	26240	0	0	0
29)	Net Deficit Funding (State & LGU Funding only)*	26110	0	10,812	2,005
30)	Other (Detail Required)	26230	0	254	1,218
31)	Total Gross Revenues (Sum Lines 15-30)	26999	936,406	11,066	888,798
GAAP ADJUSTMENTS TO REVENUE **					
32)	Participant Allowance	27010	0	0	0
33)	Uncollectible Accounts Receivable	27040	0	0	0
34)	Other (Detail Required)	27045	0	0	0
35)	Total GAAP Adjustments (Sum Lines 32-34)	27049	0	0	0
36)	Net GAAP Revenues (Line 31 minus 35)	27025	936,406	11,066	888,798
NON-GAAP ADJUSTMENTS TO REVENUE **					
37)	Exempt Contract Income	27050	0	0	0
38)	Exempt LTSE Income	27060	0	0	0
39)	Net Deficit Funding***	27070	0	10,812	2,005
40)	Other (Detail Required)	27080	0	0	0
41)	Total NON-GAAP Adjustments (Sum Lines 37-40)	27998	0	10,812	2,005
42)	Subtotal Adj. to Revenue (Sum Lines 35 & 41)	27999	0	10,812	2,005
43)	Total Net Revenues (Line 31 Minus 42)	28999	936,406	254	886,793
44)	Net Operating Cost (Line 14 Minus 43)	29999	-65,200	71,029	3,773

\* Do not include non-funded or voluntary contributions.

\*\* These amounts are the program type totals for all program/sites aggregated from Schedule CFR-1. This does not apply to agencies filing abbreviated CFR forms.

\*\*\* Amounts should equal the corresponding amounts reported as revenue on line 29 above.

Funding State Agency:  
 OMH  
 OMRDD  
 OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: January 1, 2009 TO December 31, 2009

SCHEDULE DMH-2  
 AID TO LOCALITIES/  
 DIRECT CONTRACT  
 SUMMARY

AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 COUNTY NAME & CODE: Onondaga 34

PREPARED BY: Sally Sanders  
 Please check the box if the preparer changed from the previous submission.

TELEPHONE: 315 556-5555 Ext. 123\_\_\_

PLEASE CHECK: ESTIMATED CLAIM:  FINAL CLAIM:

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3
1)	Accounting Method	Cash		Cash	Modified
2)	State Contract Number/LGU Contract Number *	ONONDAG		ONONDAG	C006363
3)	Program Type	00072	Continuing Day Treatm	Advocacy/Support Serv	Community Residence,
4)	Program Code (Program Code Index)	00012	1310 (00)	1760 (00)	7050 (00)
EXPENSES					
5)	Personal Services	18010	471,265	45,981	578,598
6)	Vacation Leave Accruals **	18020	685	845	1,312
7)	Fringe Benefits	18030	94,200	8,617	121,807
8)	Other Than Personal Services (OTPS)	18040	165,008	6,668	74,487
9)	Equipment - Provider Paid ***	18050	3,005	1,005	3,005
10)	Property - Provider Paid ****	18060	68,620	2,810	37,313
11)	Agency Administration	18080	71,428	6,068	75,828
12)	Adjustments/Non-Allowable Costs (Detail Required)	18090	0	0	0
13)	Total Adjusted Expenses (Lines 5-11 Minus 12)	18999	874,211	71,994	892,350
REVENUES					
14)	Participant Fees (less SSI & SSA)	46010	0	0	0
15)	SSI & SSA	46020	0	0	69,505
16)	Home Relief/Public Assistance	46030	0	0	0
17)	Medicaid	46040	874,928	60,200	816,070
18)	Medicare	46060	0	0	0
19)	Other Third Parties	46070	1,278	0	0
20)	OMRDD Residential Room and Board/NYS OPTS	46080	0	0	0
21)	Transportation, Medicaid	46090	0	0	0
22)	Transportation, Other	46100	0	0	0
23)	Sales: Contract Total	46140	0	0	0
24)	Federal Grants (Detail Required)	46160	0	0	0

\* For direct contracts, enter the State Contract Number. For local contracts, enter the local Contract Number, if applicable.

\*\* OASAS funded service providers cannot report vacation leave accruals for State aid reimbursement.

\*\*\* OASAS funded service providers cannot report equipment depreciations for State aid reimbursement.

\*\*\*\* OASAS funded service providers cannot report property related depreciation for State aid reimbursement.

Funding State Agency:  
 OMH  
 OMRDD  
 OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: January 1, 2009 TO December 31, 2009

SCHEDULE DMH-2  
 AID TO LOCALITIES/  
 DIRECT CONTRACT  
 SUMMARY

AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 COUNTY NAME & CODE: Onondaga 34

PREPARED BY: Sally Sanders  
 Please check the box if the preparer changed from the previous submission.

TELEPHONE: 315 556-5555 Ext. 123\_\_\_

PLEASE CHECK: ESTIMATED CLAIM:  FINAL CLAIM:

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3
	Program Type	00072	Continuing Day Treatm	Advocacy/Support Serv	Community Residence,
	Program Code (Program Code Index)	00012	1310 (00)	1760 (00)	7050 (00)
25)	State Grants (Detail Required)	46190	0	0	0
26)	LTSE Income Total (OMH and OMRDD only)	46220	0	0	0
27)	Food Stamps (OASAS Only)	46240	0	0	0
28)	Net Deficit Funding (State & LGU Funding only)*	46110	0	10,812	2,005
29)	Other (Detail Required)	46230	2,285	254	1,218
30)	Total Gross Revenues (Sum Lines 14-29)	46999	878,491	71,266	888,798
GAAP ADJUSTMENTS TO REVENUE					
31)	Participant Allowance	47010	0	0	0
32)	Uncollectible Accounts Receivable	47040	0	0	0
33)	Other (Detail Required)	47045	0	0	0
34)	Total GAAP Adjustments (Sum Lines 31-33)	47049	0	0	0
35)	Net GAAP Revenues (Line 30 minus 34)	47025	878,491	71,266	888,798
NON-GAAP ADJUSTMENTS TO REVENUE					
36)	Exempt Contract Income	47050	0	0	0
37)	Exempt LTSE Income	47060	0	0	0
38)	Net Deficit Funding**	47070	0	10,812	2,005
39)	Other (Detail Required)	47080	1,000	0	0
40)	Total NON-GAAP Adjustments (Sum Lines 36-39)	47998	1,000	10,812	2,005
41)	Subtotal Adj. to Revenue (Sum Lines 34 & 40)	47999	1,000	10,812	2,005
42)	Total Net Revenues (Line 30 minus 41)	48999	877,491	60,454	886,793
43)	Net Operating Cost (Line 13 minus 42)	49999	-3,280	11,540	5,557
DEFICIT FUNDING					
44)	State Share	60010	0	10,812	2,005
45)	Local Government Share	60020	0	0	0
46)	Service Provider Share (Voluntary Contributions)	60030	0	0	0
47)	Total Approved Deficit Funding (Sum lines 44 - 46)	60039	0	10,812	2,005
48)	Non-Funded	60040	-3,280	728	3,552
49)	Total Deficit Funding (Sum Lines 47-48)	60999	-3,280	11,540	5,557

\* Do not include non funded or voluntary contributions.

\*\* Amounts should equal the corresponding amounts reported as revenue on line 28 above.

Funding State Agency:  
 OMH  
 OMRDD  
 OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: January 1, 2009 TO December 31, 2009

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

AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 COUNTY NAME & CODE: Onondaga 34

PREPARED BY: Sally Sanders  
 Please check the box if the preparer changed from the previous submission.

TELEPHONE: 315 556-5555 Ext. 123\_\_\_\_

PLEASE CHECK: ESTIMATED CLAIM:  FINAL CLAIM:

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3	TOTAL
1) Accounting Method		Cash		Cash	Modified	
2) Program Type		00073	Continuing Day Treatm	Advocacy/Support Serv	Community Residence,	
3) Program Code (Program Code Index)		00013	1310 (00)	1760 (00)	7050 (00)	
4) Total Persons Served/Month		00220	108	100	8	
5) Total Units of Service		00999	19,005	1,719	2,628	
6) Gross Cost/Unit of Service		70999	46.00	41.88	339.55	
7) Net Cost/Unit of Service		71999	-0.17	6.71	2.11	
8) Please Check:						
9) A FUNDING SOURCE CO (Ongoing Int Spt Emp Serv.-OMH Only)   Index (		037		037		
10) Number Persons Served/Month		00260		100		100
11) Number Units of Service		00250		1,719		1,719
12) Total Adjusted Expenses		50999		71,266		71,266
13) Less Applied Net Revenue		61999		60,454		60,454
14) Net Operating Costs		62999		10,812		10,812
15) Contract Number (State/LGU)*		00201		ONONDAG		
16) B FUNDING SOURCE CO (Children CR Operating (OMH Only))   Index (OM		072	B	072	B	
17) Number Persons Served/Month		00260			8	8
18) Number Units of Service		00250			2,628	2,628
19) Total Adjusted Expenses		50999			851,485	851,485
20) Less Applied Net Revenue		61999			849,480	849,480
21) Net Operating Costs		62999			2,005	2,005
22) Contract Number (State/LGU)*		00201			C006363	
23) C FUNDING SOURCE CO (Children CR Property (OMH Only))   Index (OMH		073	B	073	B	
24) Number Persons Served/Month		00260			0	0
25) Number Units of Service		00250			0	0
26) Total Adjusted Expenses		50999			37,313	37,313
27) Less Applied Net Revenue		61999			37,313	37,313
28) Net Operating Costs		62999			0	0
29) Contract Number (State/LGU)*		00201			C006363	

\* For direct contracts, enter the State Contract Number. For local contracts, enter the local Contract Number, if applicable.

Funding State Agency:  
 OMH  
 OMRDD  
 OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: January 1, 2009 TO December 31, 2009

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

AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 COUNTY NAME & CODE: Onondaga 34

PREPARED BY: Sally Sanders  
 Please check the box if the preparer changed from the previous submission.

TELEPHONE: 315 556-5555 Ext. 123\_\_\_

PLEASE CHECK: ESTIMATED CLAIM:  FINAL CLAIM:

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3	TOTAL
1) Accounting Method		Cash		Cash	Modified	
2) Program Type		00073 Continuing Day Treatm		Advocacy/Support Serv	Community Residence,	
3) Program Code (Program Code Index)		00013 1310 (00)		1760 (00)	7050 (00)	
4) Total Persons Served/Month		00220	108	100	8	
5) Total Units of Service		00999	19,005	1,719	2,628	
6) Gross Cost/Unit of Service		70999	46.00	41.88	339.55	
7) Net Cost/Unit of Service		71999	-0.17	6.71	2.11	
8) Please Check:						
9) D FUNDING SOURCE CO (Non-Funded)   Index (OMH/OASAS)						
10) Number Persons Served/Month		00260 090	108	090   0	090   0	108
11) Number Units of Service		00250	19,005	0	0	19,005
12) Total Adjusted Expenses		50999	874,211	728	3,552	878,491
13) Less Applied Net Revenue		61999	877,491		0	877,491
14) Net Operating Costs		62999	-3,280	728	3,552	1,000
15) Contract Number (State/LGU)*		00201 ONONDAG		ONONDAG	C006363	
30) Total Adjusted Expenses		51999	874211	71994	892350	1,838,555
31) Less Net Revenue		63999	877491	60454	886793	1,824,738
32) Net Operating Costs		52999	-3280	11540	5557	13,817

\* For direct contracts, enter the State Contract Number. For local contracts, enter the local Contract Number, if applicable.

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: January 1, 2009 TO December 31, 2009

SCHEDULE SED-1  
 PROGRAM AND  
 ENROLLMENT DATA

AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110  
 SCHOOL CODE: 010205005555

Line No.	COLUMN NUMBER PROGRAM NAME PROGRAM CODE (PROGRAM CODE INDEX)	1 Preschool-Special Class over 2		2 Preschool-Special Class over 2		3 Preschool-Sp Ed Itinerant Teac		4 Preschool-Sp Ed Itinerant Teac	
		9100 (FF)	SCHOOL YEAR	9100 (SS)	SCHOOL YEAR	9135 (FF)	SCHOOL YEAR	9135 (SS)	SCHOOL YEAR
ENROLLMENT (FTE) BY FUNDING SOURCE		SUMMER	SCHOOL YEAR						
100	Non-disabled - UPK	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
101	Non-disabled - Other	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
102	Sec.4402 (Art.89) Sch. Dist. Placement	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
103	Department of Health Chapter 428	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
104	Sec.4408 (Art.89) Sch. Dist. Placement	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
105	Sec.4410 (3-4 yr olds) Sch. Dist. Placement	40.561	20.801	0.000	20.801	40.561	4.250	0.000	4.250
106	Local Social Services District	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
107	Other	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
108	Total by Funding Source (Sum Lines 102-107)	40.561	20.801	0.000	20.801	40.561	4.250	0.000	4.250
109	Number of Days in Session	30	72	0	108	30	72	0	108
110	Care Days (Line 108 times Line 109)	1,217	1,498	0	2,247	1,217	306	0	459
115	Actual SEIS or SEIT Units Provided	0	0			0	0		
201	Approved Classroom Ratio	12:1:1.0	12:1:1.0		12:1:1.0				
202	Number of Classrooms	2.00	2.00	0.00	2.00	0.00	0.00	0.00	0.00
203	Student FTE	23.500	10.801	0.000	10.801	0.000	0.000	0.000	0.000
301	Approved Classroom Ratio	06:1:2.0	06:1:2.0		06:1:2.0				
302	Number of Classrooms	2.00	2.00	0.00	2.00	0.00	0.00	0.00	0.00
303	Student FTE	11.900	5.450	0.000	5.450	0.000	0.000	0.000	0.000
401	Approved Classroom Ratio	06:1:1.0	06:1:1.0		06:1:1.0				
402	Number of Classrooms	1.00	1.00	0.00	2.00	0.00	0.00	0.00	0.00
403	Student FTE	5.161	4.550	0.000	4.550	0.000	0.000	0.000	0.000
501	Approved Classroom Ratio								
502	Number of Classrooms	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
503	Student FTE	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
601	Approved Classroom Ratio								
602	Number of Classrooms	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
603	Student FTE	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
701	Approved Classroom Ratio								
702	Number of Classrooms	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
703	Student FTE	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
801	Approved Classroom Ratio								
802	Number of Classrooms	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
803	Student FTE	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
901	Approved Classroom Ratio								
902	Number of Classrooms	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
903	Student FTE	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
999	Total Student FTE	40.561	20.801	0.000	20.801	0.000	0.000	0.000	0.000

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: July 1, 2008 TO June 30, 2009

Agency Name: Any Agency Inc.  
 Agency Code: 11110  
 School Code: 010205005555  
 Program Code: 9100 (XX)

Contact Person: Sally Sanders  
 Phone Number: 315 556-5555 Ext. 123\_\_

Column 1  Related Service	Capacity				Need					Productivity	
	Column 2a Annual Related Service Employee FTE Allocated to Program	Column 2b Annual Contracted Related Service Hours	Column 2c Program Hours Per Week	Column 3 Annual Capacity of Related Service Time in Half-Hour Units (Column 2a x 52 Weeks x column 2c x 2) + (Column 2b x 2)	Column 4a Annual IEP Mandated Individual Related Service Sessions on All Students IEPs	Column 4b Annual IEP Mandated Group Related Service Sessions on All Students IEPs	Column 4c Average # of Students Served in Group	Column 4d Annual Group Sessions (Column 4b divided by Column 4c)	Column 4e Annual IEP Mandated Half-Hour Related Service Sessions (Sum Columns 4a and 4d)	Column 5 Annual IEP Mandated Half-Hour Related Service Sessions (RS-2 col 7a +(RS-2 col 7b / SED-4 col 4c))	Column 6 Percentage of Time Related Service Sessions Provided (Column 5 Divided By Column 3)
Speech Therapy	0.982	30	25	2,613.20	2,200.00	547.00	2.00	274	2,473.50	2,175.00	83.2313
Physical Therapy	0.900	0	25	2,340.00	2,015.00	375.00	3.00	125	2,140.00	1,977.00	84.4872
Occupational Therapy	0.023	0	25	59.80	50.00	0.00	0.00	0	50.00	47.00	78.5953
Counseling	0.000	0	25	0.00	0.00	0.00	0.00	0	0.00	0.00	0.0000
Skilled Nursing	0.000	0	25	0.00	0.00	0.00	0.00	0	0.00	0.00	0.0000
Other	0.000	0	25	0.00	0.00	0.00	0.00	0	0.00	0.00	0.0000

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: January 1, 2009 TO December 31, 2009

RECONCILIATION

AGENCY CODE: 11110

AGENCY NAME: Any Agency Inc.

Total agency expenses from Financial Statements	8,989,632	Total agency Revenues from Financial Statements	9,396,977
Additions:		Additions:	0
Depreciation variance	1,000	Subtractions:	
Total Additions:	1,000	Prior Year Adjustment	47,021
Subtractions:	0	Total Subtractions:	47,021
Total adjustments:	1,000	Total Adjustments:	-47,021
Adjusted Financial Statement Expenses	8,990,632	Adjusted Financial Statement Revenues	9,349,956
Total agency Expenses from CFR-2, Col. 1, lines 8 + 9	8,990,461	Total agency Revenues from CFR-2, Col. 1, line 12	9,349,602
Difference	171	Difference	354

[ X ] OMH [ ] SED  
[ ] OMRDD  
[ ] OASAS

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: January 1, 2009 TO December 31, 2009

WORKSHEET/OTHER  
DETAILS

PAGE 44

-----  
AGENCY CODE: 11110

AGENCY NAME: Any Agency Inc.  
-----

SCHEDULE: CFR-1

PROGRAM: 1310 (00)  
SITE: 1111052

PROGRAM: 1760 (00)  
SITE: 1111050

PROGRAM: 1760 (00)  
SITE: 1111276

Line 39 Other Insurance 3,182  
Line 40 Data Processing 7,692  
Line 74 Other Third Parties 1,278

Line 39 Other Insurance 17  
Line 40 Contracted Support Personal Service 127  
Line 94 All Items <\$1,000 Each 123

Line 39 Other Insurance 17  
Line 40 Contracted Support Personal Service 127  
Line 94 All Items <\$1,000 Each 131

[ X ] OMH [ ] SED  
[ ] OMRDD  
[ ] OASAS

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: January 1, 2009 TO December 31, 2009

WORKSHEET/OTHER  
DETAILS

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-----  
AGENCY CODE: 11110

AGENCY NAME: Any Agency Inc.  
-----

SCHEDULE: CFR-1

PROGRAM: 7050 (00)  
SITE: 1111975

Line 39	Other Insurance	3,295
Line 62	All Items <\$1,000 Each	1,522
Line 94	All Items <\$1,000 Each	168

[ ] OMH [ X ] SED  
[ ] OMRDD  
[ ] OASAS

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: January 1, 2009 TO December 31, 2009

WORKSHEET/OTHER  
DETAILS

PAGE 46

-----  
AGENCY CODE: 11110

AGENCY NAME: Any Agency Inc.  
-----

SCHEDULE: CFR-1

PROGRAM: 9100 (FF)  
SITE: 1111910

PROGRAM: 9100 (SS)  
SITE: 1111910

PROGRAM: 9135 (FF)  
SITE: 1111913

Line 39 Other Insurance 450  
Line 40 Data Processing 100  
All Items <\$1,000 Each 175  
Line 47 All Items <\$1,000 Each 151  
parking tickets 324  
Line 62 All Items <\$1,000 Each 346  
Line 66 Line [47] - parking tickets 324  
Line 94 All Items <\$1,000 Each 12

Line 39 Other Insurance 450  
Line 40 Data Processing 100  
All Items <\$1,000 Each 175  
Line 47 All Items <\$1,000 Each 475  
Line 62 All Items <\$1,000 Each 346  
Line 94 All Items <\$1,000 Each 13

Line 40 Data Processing 8  
All Items <\$1,000 Each 8

[ ] OMH [ X ] SED  
[ ] OMRDD  
[ ] OASAS

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: January 1, 2009 TO December 31, 2009

WORKSHEET/OTHER  
DETAILS

PAGE 47

-----  
AGENCY CODE: 11110

AGENCY NAME: Any Agency Inc.  
-----

SCHEDULE: CFR-1

PROGRAM: 9135 (SS)  
SITE: 1111913

PROGRAM: 9190 (FF)  
SITE: 1111910

PROGRAM: 9190 (SS)  
SITE: 1111910

Line 40 Data Processing 8  
All Items <\$1,000 Each 8

Line 39 Other Insurance 128

Line 39 Other Insurance 128

Line 40 Data Processing 33  
All Items <\$1,000 Each 45

Line 40 Data Processing 30  
All Items <\$1,000 Each 45

Line 47 All Items <\$1,000 Each 135

Line 47 All Items <\$1,000 Each 135

Line 62 All Items <\$1,000 Each 198

Line 62 All Items <\$1,000 Each 198

Line 94 All Items <\$1,000 Each 9

[ ] OMH [ X ] SED  
[ ] OMRDD  
[ ] OASAS

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: January 1, 2009 TO December 31, 2009

WORKSHEET/OTHER  
DETAILS

PAGE 48

-----  
AGENCY CODE: 11110

AGENCY NAME: Any Agency Inc.  
-----

SCHEDULE: CFR-1

PROGRAM: 9805 (FF)  
SITE: 1111980

PROGRAM: 9805 (SS)  
SITE: 1111980

Line 94 Section 611/619 IDEA Money 750

Line 94 Section 611/619 IDEA Money 750

OMH     SED  
 OMRDD  
 OASAS

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: January 1, 2009 TO December 31, 2009

WORKSHEET/OTHER  
DETAILS

PAGE 49

-----  
AGENCY CODE: 11110

AGENCY NAME: Any Agency Inc.  
-----

SCHEDULE: CFR-3

Line 16	General Liability	4,900
Line 17	Data Processing	1,587

[ X ] OMH [ ] SED  
[ ] OMRDD  
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NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: January 1, 2009 TO December 31, 2009

WORKSHEET/OTHER  
DETAILS

PAGE 50

-----  
AGENCY CODE: 11110

AGENCY NAME: Any Agency Inc.  
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SCHEDULE: DMH-2

PROGRAM: 1310 (00)  
COUNTY: 34 - Onondaga

PROGRAM: 1760 (00)  
COUNTY: 34 - Onondaga

PROGRAM: 7050 (00)  
COUNTY: 34 - Onondaga

Line 17 Base Medicaid 799,399  
Level 1 COPS 75,529  
Line 19 Other Third Parties 1,278  
Line 29 Level 1 COPS Prior Years 2,285  
Line 39 Level II COPS Reserve 1,000

Line 17 CSP 60,200  
Line 29 All Items <\$1,000 Each 254

Line 17 Base Medicaid 816,070  
Line 29 All Items <\$1,000 Each 1,218

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**SCHEDULE OMH-1**  
**UNITS OF SERVICE**  
**BY PROGRAM/SITE**

Page \_\_\_\_\_

AGENCY NAME: \_\_\_\_\_  
 AGENCY CODE: \_\_\_\_\_

Line No.	COLUMN NUMBER	1			2			3			4						
	PROGRAM CODE (PROGRAM CODE INDEX)	1310 (00)			1760 (00)			1760 (00)			7050 (00)			( )			
	PROGRAM TYPE	Continuing Day Treatment			Advocacy/Support Services			Advocacy/Support Services			Community Resid. Children						
	PROG/SITE ID. #	1111052			1111050			1111276			1111975						
	TYPE OF SERVICE (PROGRAM CODE)	WEIGHT FACTOR	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS
	<b>Partial Hospitalization (2200)</b>																
1	Regular																
2	Collateral																
3	Group Collateral																
4	Crisis																
	<b>Intensive Psychiatric Rehab. (2320)</b>																
5	Regular																
	<b>Clinic Treatment (2100)</b>																
6	Brief	0.50															
7	Regular	1.00															
8	Group	0.35															
9	Collateral	1.00															
10	Group Collateral	0.35															
11	Crisis	1.00															
	<b>Day Treatment (0200)</b>																
	<b>Sheltered Workshop (0340)</b>																
	<b>On Site Rehabilitation (0320)</b>																
	<b>Continuing Day Treatment (1310)</b>																
12	Brief Day	0.33															
13	Half Day	0.50	8566	4283													
14	Full Day	1.00	14722	14722													
15	Collateral	0.33															
16	All Other	1.00				839	839		860	860							
17	Residential (Patient Days)	1.00										2628	2628				
18	<b>Total</b>		<b>23288</b>	<b>19005</b>		<b>839</b>	<b>839</b>		<b>860</b>	<b>860</b>		<b>2628</b>	<b>2628</b>				

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**SCHEDULE OMH-2**  
**MEDICAID**  
**UNITS OF SERVICE**  
**BY PROGRAM/SITE**

Page \_\_\_\_\_

AGENCY NAME: \_\_\_\_\_  
 AGENCY CODE: \_\_\_\_\_

Line No.	COLUMN NUMBER	1			2			3			4						
	PROGRAM CODE (PROGRAM CODE INDEX)	1310 (00)			1760 (00)			1760 (00)			7050 (00)			( )			
	PROGRAM TYPE	Continuing Day Treatment			Advocacy/Support Services			Advocacy/Support Services			Community Resid. Children						
	PROG/SITE ID. #	1111052			1111050			1111276			1111975						
	TYPE OF SERVICE (PROGRAM CODE)	WEIGHT FACTOR	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS
	<b>Partial Hospitalization (2200)</b>																
1	Regular																
2	Collateral																
3	Group Collateral																
4	Crisis																
	<b>Intensive Psychiatric Rehab. (2320)</b>																
5	Regular																
	<b>Clinic Treatment (2100)</b>																
6	Brief	0.50															
7	Regular	1.00															
8	Group	0.35															
9	Collateral	1.00															
10	Group Collateral	0.35															
11	Crisis	1.00															
	<b>Day Treatment (0200)</b>																
	<b>Continuing Day Treatment (1310)</b>																
12	Brief Day	0.33															
13	Half Day	0.50	7810	3905													
14	Full Day	1.00	12822	12822													
15	Collateral	0.33															
16	All Other	1.00															
17	Residential (Patient Days)	1.00										2628	2628				
18	<b>Total</b>		<b>20632</b>	<b>16727</b>								<b>2628</b>	<b>2628</b>				

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AGENCY NAME: Any Agency Inc.  
 AGENCY CODE: 11110

Line No.	COLUMN NUMBER	1	2	3	4
	PROGRAM CODE	1310 (00)	1760 (00)	1760 (00)	7050 (00)
	PROGRAM TYPE	Continuing Day Treatment	Advocacy/Support Services	Advocacy/Support Services	Community Residence, Childr
	PROG/SITE ID.#	1111052	1111050	1111276	1111975

PERSONS SERVED DURING THE YEAR

1) Persons on Rolls Beginning of Year	100	24	26	8
2) New Persons added to Rolls	100	26	24	1
3) Persons Removed from Rolls	92	24	26	1
4) Persons on Rolls, End of Year	108	26	24	8

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**SCHEDULE OMH-4**  
**UNITS OF SERVICE**  
**BY PAYOR**  
**BY PROGRAM/SITE**

Page \_\_\_\_\_

AGENCY NAME: \_\_\_\_\_  
 AGENCY CODE: \_\_\_\_\_

Line No.	PROGRAM CODE (PROGRAM CODE INDEX) PROGRAM TYPE PROG/SITE ID. #	TOTAL VISITS	Revenue Earned By Payor
<b>1</b>	<b>Totals From OMH-1</b>		
<b>Payors:</b>			
<b>2</b>	<b>Medicaid</b>		
<b>3</b>	<b>Medicaid Managed Care</b>		
<b>4</b>	<b>Child and Family Health Plus</b>		
<b>5</b>	<b>Medicare</b>		
<b>6</b>	<b>Other Private Insurance</b>		
<b>7</b>	<b>Participant Fees- Copays and Deductibles</b>		
<b>Uncompensated Care:</b>			
<b>8</b>	<b>Participant Fees- Not Including Copays</b>		
<b>9</b>	<b>Third Party - Non-Covered Services</b>		
<b>10</b>	<b>Third Party - Non-Eligible Licensed Staff</b>		
<b>11</b>	<b>Third Party- Non-Eligible Out of Network</b>		
<b>12</b>	<b>Total Visits (Sum of Lines 2-11)*</b>		
<b>13</b>	<b>Visits Eligible for Uncompensated Care Reimbursement (Sum Lines 8-11)</b>		
<b>14</b>	<b>Uncompensated Care Visits (Line 13) as Percent of Total Visits (Line 12)</b>		

\* Line 12 Visits should equal Line 1 Visits.

OMH-4  
 Rev. October 2009

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**SCHEDULE OMRDD-1**  
**SCHEDULE OF SERVICES -**  
**ICF/DDs Only**

AGENCY NAME: \_\_\_\_\_  
 AGENCY CODE: \_\_\_\_\_  
 MEDICAID PROVIDER AGREEMENT NUMBER: \_\_\_\_\_

SITE ADDRESS: \_\_\_\_\_  
 PROGRAM TYPE & CODE NUMBER: \_\_\_\_\_  
 OPERATING CERTIFICATE NUMBER: \_\_\_\_\_

Complete a separate schedule for each site. For each service type or supply, check Cols. 1, 2 or 3. If Col. 2 or 3 is checked, show the dollar amount associated with Col. 2 or 3 in Column 4.

Line No.	SERVICE TYPE	Col. 1	Col. 2	Col. 3	Col. 4	Line No.	SERVICE TYPE	Col. 1	Col. 2	Col. 3	Col. 4
		Exclusively Purchased w/ Medicaid Card	Exclusively Purchased by ICF	ICF Purchases Made Only Where MA Card Did Not Cover Items	ICF Purchase Amount Associated w/ Col. 2 or 3			Exclusively Purchased w/ Medicaid Card	Exclusively Purchased by ICF	ICF Purchases Made Only Where MA Card Did Not Cover Items	ICF Purchase Amount Associated w/ Col. 2 or 3
<b>Pharmacy Services</b>						<b>Aide Services</b>					
1	Prescription Drugs + Insulin					26	Home Health Aide				
2	Non-Prescription Drugs					27	Personal Care Aide				
3	Medical Gloves					<b>Medical Services</b>					
4	Enteral Formulae					28	General Medical - Direct Service				
5	Diapers/Underpads					29	General Medical - Consultation				
6	Other Medical Supplies*					30	Physician - Direct Service				
<b>Equipment</b>						31	Physician - Consultation				
7	Durable Medical					32	Psychiatrist - Direct Service				
8	Prosthetic & Orthotic					33	Psychiatrist - Consultation				
<b>Service Coordination</b>						34	All Dental Services				
9	Service Coordination					35	Clinical Laboratory				
<b>Transportation Services</b>						36	X-Ray Diagnostic				
10	To Medical Office/Clinic					37	Other (Detail Required)				
<b>Therapy Services (See Definition)</b>						<b>Complete this section only if this site is funded for Day Services within the ICF/DD Rate</b>					
11	Long Term - Occupational Therapy					38	Day Programming				
12	Long Term - Physical Therapy					39	Day Training				
13	Long Term - Psychologist Services					40	Sheltered Workshop				
14	Long Term - Speech and Language Pathology					41	Education				
15	Long Term - Dietetics and Nutrition					<p><b>Definitions and Notes:</b></p> <p><b>Consultation</b> - Practitioner provides training, oversight and direction to direct care staff.</p> <p><b>Direct Service</b> - Practitioner directly treats the consumers.</p> <p><b>Nursing</b> - Excludes medical services provided by a nurse practitioner.</p> <p>*Other Medical Supplies: If Column 2 or 3 is checked, complete Schedule OMRDD-2 for each site as well.</p> <p>**Service must be directly related to an acute illness, accident or post-hospitalization health need. If purchased with a Medicaid card, this acute care/rehabilitation service is limited to 3 consecutive months in a calendar year.</p>					
16	Long Term - Rehabilitation Counseling										
17	Long Term - Social Work										
18	Long Term - Nursing										
19	Acute Care - Occupational Therapy **										
20	Acute Care - Physical Therapy **										
21	Acute Care - Psychologist Services **										
22	Acute Care - Speech and Language Pathology **										
23	Acute Care - Dietetics and Nutrition **										
24	Acute Care - Nursing **										
25	Other (Detail Required)										

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**SCHEDULE OMRDD-2**  
**ICF/DD**  
**MEDICAL SUPPLIES**

Page \_\_\_\_\_

<b>AGENCY NAME:</b> _____ <b>AGENCY CODE:</b> _____ <b>MEDICAID PROVIDER AGREEMENT NUMBER:</b> _____	<b>PROGRAM TYPE &amp; CODE NUMBER:</b> _____ <b>OPERATING CERTIFICATE:</b> _____
--	---

Complete this schedule if "YES" was checked on line 6 (Other Medical Supplies) in either column 2 or 3 of schedule OMRDD-1.  
 This schedule should show specifically which items of medical supplies are included or not included in the costs reported on Schedules CFR-1 and OMRDD-1 .

Line NO.	MEDICAL SUPPLY DESCRIPTION	INCLUDED	NOT INCLUDED		Line NO.	MEDICAL SUPPLY DESCRIPTION	INCLUDED	NOT INCLUDED
1	ADHESIVE TAPE				17	GAUZE PADS - STERILE		
2	ADHESIVE BANDAGES				18	GAUZE PADS - NON-STERILE		
3	ADHESIVE PLASTERS				19	IRRIGATION SUPPLIES		
4	ANTISEPTICS				20	OSTOMY CARE PRODUCTS		
5	CANES				21	LAMBS WOOL		
6	CATHETERS				22	SYNTHETIC SHEEP SKIN*		
7	CLOTH/CLOTH-LIKE PRODUCTS				23	LUBRICATING JELLY		
8	COMMODE ACCESSORIES				24	MASTECTOMY PRODUCTS		
9	CONSTIPATION AIDS				25	RESPIRAT./TRACH. CARE PRODUCT		
10	COTTON/COTTON-LIKE PRODUCTS				26	RUBBER FLAT GOODS		
11	CRUTCHES				27	RUBBER MOLDED GOODS		
12	DIABETIC DIAGNOSTICS				28	SUPPORTED GOODS		
13	DIABETIC DAILY CARE				29	SYRINGES		
14	ELECTRIC COOL/HEAT PADS				30	THERMOMETERS		
15	EYE CARE SUPPLIES				31	OTHER (Detail Required)		
16	GAUZE ROLLS							

\* Include all Decubitus supplies here.

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**SCHEDULE OMRDD-3**  
**HUD REVENUES**  
**AND EXPENSES**

AGENCY NAME: \_\_\_\_\_  
 AGENCY CODE: \_\_\_\_\_  
 MEDICAID PROVIDER AGREEMENT NUMBER: \_\_\_\_\_

PROGRAM TYPE & CODE NUMBER: \_\_\_\_\_  
 OPERATING CERTIFICATE: \_\_\_\_\_

	<u>AMOUNT</u>		<u>LINE # CFR-1</u>	<u>AMOUNT</u>
<b>A. <u>HUD SECTION 8/811 SUBSIDY:*</u></b> (From Commitment Form HUD 92264)	\$ _____	<b>D. <u>EXPENSES INCLUDED ON SCHEDULE CFR-1</u></b>		
<b>B. <u>REVENUE:</u></b>		1. MORTGAGE	_____	\$ _____
1. HUD Section 8/811 Revenues	\$ _____	2. REAL ESTATE TAXES	_____	\$ _____
2. Other (Detail Required)	\$ _____	3. REPAIRS AND MAINTENANCE	_____	\$ _____
3. Other (Detail Required)	\$ _____	4. MORTGAGE INT. OPERATING EXPENSES	_____	\$ _____
4. Other (Detail Required)	\$ _____	5. INSURANCE	_____	\$ _____
5. Other (Detail Required)	\$ _____	6. GROUNDSKEEPING	_____	\$ _____
<b>TOTAL REVENUE(Add Lines B1-B5)</b>	\$ _____	7. UTILITIES	_____	\$ _____
		8. OTHER (Detail Required) _____	_____	\$ _____
<b>C. <u>REVENUE OFFSETS:</u></b>		9. OTHER (Detail Required) _____	_____	\$ _____
1. Replacement Reserve Offset	\$ _____	10. OTHER (Detail Required) _____	_____	\$ _____
(HUD 92264, Line # 21)		11. OTHER (Detail Required) _____	_____	\$ _____
2. Participant Contribution	\$ _____	12. OTHER (Detail Required) _____	_____	\$ _____
(30% of Adjusted Participant Income)		13. OTHER (Detail Required) _____	_____	\$ _____
3. Other (Detail Required)	\$ _____			
4. Other (Detail Required)	\$ _____	<b>TOTAL EXPENSES (Add Lines D1-D13)</b>		\$ _____
5. Other (Detail Required)	\$ _____			
<b>TOTAL OFFSETS (Add Lines C1-C5)</b>	\$ _____			

\*HUD Section 8 Subsidy- Estimated project Gross Income based on number of units times Unit Rent per month at 100% occupancy.

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SCHEDULE OMRDD-4  
FRINGE BENEFIT EXPENSE AND  
PROGRAM ADMINISTRATION EXPENSE DETAIL

Page \_\_\_\_\_

AGENCY NAME: \_\_\_\_\_ AGENCY CODE: \_\_\_\_\_

Line No.	COLUMN NUMBER				
	PROGRAM/SITE ID#				
	PROGRAM TYPE & CODE				
	ITEM DESCRIPTION				
	<b>FRINGE BENEFITS</b>				
1	Social Security				
2	Workers' Compensation				
3	Unemployment Insurance				
4	NYS Disability				
5	Sick Leave Accruals				
6	Health/Dental Insurance				
7	Life Insurance				
8	Pension/Retirement				
9	Other (Detail Required)				
10	Total (Add lines 1 - 9; must equal CFR-1, line 20)				

**PROGRAM ADMINISTRATION (Report the amount included on each specified CFR-1 line that is associated with Program Administration for each site.)**

11	Personal Services (CFR-1, Line 16)				
12	Vacation Leave Accruals (CFR-1, Line 17)				
13	Fringe Benefits (CFR-1, Line 20)				
14	Repairs and Maintenance (CFR-1, Line 22)				
15	Utilities (CFR-1, Line 23)				
16	Staff Travel (CFR-1, Line 25)				
17	Expensed Equipment (CFR-1, Line 28)				
18	Staff Development (CFR-1, Line 34)				
19	Supplies and Materials - non-Household (CFR-1, Line 36)				
20	Telephone (CFR-1, Line 38)				
21	Insurance General (CFR-1, Line 39)				
22	Other OTPS (CFR-1, Line 40) (Detail Required)				
23	Equipment (CFR-1, Line 48)				
24	Property (CFR-1, Line 63)				
25	Adjustments (CFR-1, Line 66) (Detail Required)				
26	Totals (Add lines 11 - 24 minus 25)*				

\* This total must equal the portion of CFR-1, line 67, that is directly associated with program administration.