

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: July 1, 2010 TO June 30, 2011

AGENCY NAME: Any Agency, Inc.  
AGENCY ADDRESS: 24 Phillips St  
New York, New York 10003-1234  
 Please check the box if the agency address changed from the prior reporting period.

AGENCY CODE: 11110  
COUNTY NAME: New York  
COUNTY CODE: 31

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

Person to Contact with Regard to Questions Concerning this Report:

Ms. Sally Sanders 212 355-5555 Ext. 123  
-----  
Name Telephone Number  
Accountant 212 355-6666  
-----  
Title FAX Number  
ssanders@anyagency.org  
-----  
E-mail Address

SCHOOL CODE (SED ONLY): 010205005555

FEDERAL EMPLOYER ID NUMBER: 01-2345678

CHECK THE STATE AGENCY(IES):  OMH  
 OPWDD  
 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.

10/14/2011  
-----  
Date

212 355-7778 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: July 1, 2010 TO June 30, 2011

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 June 30, 2011 and the accompanying related statements of operations, changes in net assets or equity, and cash flows for the year then ended. These financial statements are the responsibility of the Agency's/County's management. Our responsibility is to express an opinion on these financial statements based on our audit.

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

In our opinion, the aforementioned financial statements present fairly, in all material respects, the financial position of the Agency/County as of June 30, 2011 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; CFR-6, Section 3; DMH-1; OMH-1; OMH-4; OPWDD-3; OPWDD-4; SED-1; and SED-4, 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 75221313 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 75221313, not detailed in the preceding paragraph, was not audited by us and, accordingly, we express no opinion thereon.

We have examined the above detailed schedules' conformity with the applicable instructions relating to the preparation of those schedules contained within the Consolidated Fiscal Reporting and Claiming Manual for the year ended June 30, 2011. 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 for People With Developmental Disabilities, New York State Office of Mental Health, New York State Office of Alcoholism and Substance Abuse, and New York State Education Department for the year ended June 30, 2011.

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.

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: July 1, 2010 TO June 30, 2011

10/14/2011

-----  
Date CFR-ii signed

09/07/2011

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

315 222-3535

-----  
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

12-34567

-----  
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 for People With 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)
10/14/2011	
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 New York - 31
Unit: _____
Date: _____

Funding State Agency:  
 OMH     SED  
 OPWDD  
 OASAS

NEW YORK STATE  
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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
SECTION A: GENERAL INFORMATION						
1)	Program Type	00070 Advocacy/Support Services		Advocacy/Support Services	Clinic Treatment	Community Residence, Children
2)	Program Code (Program Code Index)	00010 1760 (00)		1760 (00)	2100 (00)	7050 (00)
3)	Program/Site Identification Number	00050 1111050		1111276	1111052	1111975
4)	Program/Site Name	00020 OMH Answers		OMH Shoulders	Bunn Street Clinic	Regency House
5)	Program/Site Address (Line One)	00030 29 Stewart St		22 My Way Drive	25 Bunn St	200 105th St
6)	Program/Site Address (Line Two)	00040 New York, NY 10001-3101		New York, NY 10003-1111	New York, NY 10014-1111	New York, NY 10012-1122
7a)	Medicaid Provider Agreement Number (DMH only)	00060			00257811	01504883
7b)	National Provider ID Number (DMH Only)	00061			1806077777	1706623456
8)	County Code (See Appendix C)	00080 31		31	31	31
9)	Date Site Opened	00090 06/01/1996		01/01/2001	02/02/1992	01/16/1991
10)	Certified Capacity (OASAS, OPWDD and SED only)	00100	0	0	0	0
11)	Actual Capacity (OMH, OPWDD and SED only)	00110	0	0	330	8
12)	Actual Days Program/Site Open	00160	135	135	253	365
13)	Units Of Service	00120	632	673	5,621	2,508
14)	Respite or TUBS Units of Service (OPWDD only)	00130	0	0	0	0
15)	Program/Site Square Footage (OASAS, OPWDD and SED Only)	00150	0	0	0	0

Funding State Agency:  
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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
	Program Code (Program Code Index)		1760 (00)	1760 (00)	2100 (00)	7050 (00)
	Program/Site Identification Number		1111050	1111276	1111052	1111975
SECTION B: EXPENSES						
PERSONAL SERVICES						
16)	Personal Services-Program/Site & Program Admin*	11999	22,987	22,994	372,548	578,598
17)	Vacation Accruals-Program/Site & Program Admin*	12999	414	431	685	1,312
FRINGE BENEFITS						
18)	Mandated Fringe Benefits	13200	2,281	2,283	36,957	57,397
19)	Non-Mandated Fringe Benefits	13300	3,968	3,969	64,302	99,866
20)	Total Fringe Benefits (Sum Lines 18 & 19)	13999	6,249	6,252	101,259	157,263
OTHER THAN PERSONAL SERVICES (OTPS)						
21)	Food	14010	0	0	0	17,861
22)	Repairs and Maintenance	14020	272	272	21,412	11,204
23)	Utilities	14030	681	681	25,737	9,522
24)	Transportation Related - Participant**	14040	16	16	0	11,176
25)	Staff Travel	14250	1,950	1,211	120	134
26)	Participant Incidentals	14050	0	0	4,804	3,903
27)	Expensed Adaptive Equipment (OPWDD and SED only)	14070	0	0	0	0
28)	Expensed Equipment	14080	83	23	1,768	0
29)	Sub-Contract Raw Materials	14090	0	0	0	0
30)	Participant Wages - Non-Contract	14100	0	0	0	0

Funding State Agency:  
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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)		1760 (00)	1760 (00)	2100 (00)	7050 (00)
	Program/Site Identification Number		1111050	1111276	1111052	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 (OPWDD only)	14130	0	0	0	0
34)	Staff Development	14140	45	184	3,628	3,255
35)	Contracted Direct Care and Clinical Personal Services (from CFR-4A)	14150	0	0	71,885	0
36)	Supplies and Materials - Non-Household	14160	81	43	8,748	1,587
37)	Household Supplies	14170	182	181	3,524	5,517
38)	Telephone	14190	231	228	7,910	7,033
39)	Insurance - General	14260	17	17	3,182	3,295
40)	Other (Detail Required)	14998	127	127	7,692	0
41)	Total Other Than Personal Services (Sum Lines 21-40)	14999	3,685	2,983	160,410	74,487
	EQUIPMENT - PROVIDER PAID					
42)	Lease/Rental Vehicle	15010	0	0	1,600	0
43)	Lease/Rental Equipment	15020	0	0	1,000	0
44)	Depreciation - Vehicle	15040	21	21	0	1,221
45)	Depreciation - Equipment	15050	126	126	0	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	147	147	2,600	1,221
	PROPERTY - PROVIDER PAID					
49)	Lease/Rental - Real Property	16010	1,105	1,205	68,620	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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SCHEDULE CFR-1  
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 AGENCY NAME: Any Agency, Inc.  
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 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)		1760 (00)	1760 (00)	2100 (00)	7050 (00)
	Program/Site Identification Number		1111050	1111276	1111052	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	243	292	998	3,013
56)	Real Estate Taxes	16090	0	0	0	847
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	1,348	1,497	69,618	37,312
TOTALS						
64)	Total Operating Costs (Sum lines 16,17,20,41 minus 29)	19010	33,335	32,660	634,902	811,660
65)	Agency Admin. Alloc.* (Line 64 times 0.097691)	19050	3,257	3,191	62,024	79,292
66)	Adjustments/Non-Allowable Costs (Detail Required)	19030	0	0	1,000	0
67)	Total Prog/Site Costs (Sum lines 29, 48, 63-65 minus 66)	19060	38,087	37,495	768,144	929,485
OPWDD 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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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
	Program Code (Program Code Index)		1760 (00)	1760 (00)	2100 (00)	7050 (00)
	Program/Site Identification Number		1111050	1111276	1111052	1111975
SECTION C: REVENUES						
69)	Participant Fee (Less SSI & SSA)	20010	0	0	19,786	0
70)	SSI and SSA	20020	0	0	0	69,505
71)	Home Relief/Public Assistance	20030	0	0	0	0
72)	Medicaid	20040	0	0	756,882	868,526
73)	Medicare	20060	0	0	68,626	0
74)	Other Third Parties (Detail Required)	20070	0	0	1,278	0
75)	OPWDD 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 OPWDD only)	22080	0	0	0	0
82)	Food Stamps (OASAS, OPWDD), 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 OPWDD programs, if this line is completed, complete Schedule OPWDD-3 (HUD Revenues and Expenses).  
 \*\* Refer to CFR manual for specific instructions.

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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)		1760 (00)	1760 (00)	2100 (00)	7050 (00)
	Program/Site Identification Number		1111050	1111276	1111052	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	2,000	2,000	0	0
94)	Other (Detail Required)	22998	123	113	0	168
95)	Gross Revenues (Sum Lines 69-94)	23999	2,123	2,113	846,572	939,249
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	2,123	2,113	846,572	939,249
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	2,000	2,000	0	0
104)	Other (Detail Required)	24080	0	0	0	0
105)	Total NON-GAAP Adjustments (Sum Lines 101-104)	24097	2,000	2,000	0	0
106)	TOTAL ADJ. TO REVENUE (Sum Lines 99 & 105)	24999	2,000	2,000	0	0
107)	TOTAL NET REVENUES (Line 95 minus 106)	25999	123	113	846,572	939,249

\* 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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NEW YORK STATE  
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SCHEDULE CFR-1  
 PROGRAM/SITE  
 DATA

AGENCY NAME: Any Agency, Inc.  
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Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3	4
SECTION A: GENERAL INFORMATION						
1)	Program Type	00070	Preschool-Special Class over	Preschool-Sp Ed Itinerant Tea	Preschool-Evaluations	Federal Grants (611)
2)	Program Code (Program Code Index)	00010	9100 (YY)	9135 (YY)	9190 (YY)	9805 (YY)
3)	Program/Site Identification Number	00050	1111910	1111913	1111919	1111980
4)	Program/Site Name	00020	Center (based 5 hours)	Pre. Sch, Spec Ed. Itineran	Preschool Evauations	611 Grants
5)	Program/Site Address (Line One)	00030	53 Bunn St	50 East 42nd Street	53 Bunn St	53 Bunn St
6)	Program/Site Address (Line Two)	00040	New York, NY 10014-1111	New York, NY 10003-1111	New York, NY 10014-1111	New York, NY 10014-1111
7a)	Medicaid Provider Agreement Number (DMH only)	00060				
7b)	National Provider ID Number (DMH Only)	00061				
8)	County Code (See Appendix C)	00080	31	31	31	31
9)	Date Site Opened	00090				
10)	Certified Capacity (OASAS, OPWDD and SED only)	00100	45	0	0	0
11)	Actual Capacity (OMH, OPWDD and SED only)	00110	22	0	0	0
12)	Actual Days Program/Site Open	00160	0	0	0	0
13)	Units Of Service	00120	0	2,324	265	0
14)	Respite or TUBS Units of Service (OPWDD only)	00130	0	0	0	0
15)	Program/Site Square Footage (OASAS, OPWDD and SED Only)	00150	3,000	0	0	0

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Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1 9100 (YY) 1111910	2 9135 (YY) 1111913	3 9190 (YY) 1111919	4 9805 (YY) 1111980
SECTION B: EXPENSES						
PERSONAL SERVICES						
16)	Personal Services-Program/Site & Program Admin*	11999	308,295	46,133	37,314	0
17)	Vacation Accruals-Program/Site & Program Admin*	12999	6,045	202	816	0
FRINGE BENEFITS						
18)	Mandated Fringe Benefits	13200	27,747	4,648	3,381	0
19)	Non-Mandated Fringe Benefits	13300	52,410	7,842	6,343	0
20)	Total Fringe Benefits (Sum Lines 18 & 19)	13999	80,157	12,490	9,724	0
OTHER THAN PERSONAL SERVICES (OTPS)						
21)	Food	14010	800	0	0	0
22)	Repairs and Maintenance	14020	120	213	261	0
23)	Utilities	14030	3,072	0	828	0
24)	Transportation Related - Participant**	14040	375	0	106	0
25)	Staff Travel	14250	250	17	61	0
26)	Participant Incidentals	14050	0	0	0	0
27)	Expensed Adaptive Equipment (OPWDD and SED only)	14070	0	0	0	0
28)	Expensed Equipment	14080	931	0	264	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  
 OPWDD  
 OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: July 1, 2010 TO June 30, 2011

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 9100 (YY) 1111910	2 9135 (YY) 1111913	3 9190 (YY) 1111919	4 9805 (YY) 1111980
31)	Participant Wages-Contract	14110	0	0	0	0
32)	Participant Fringe Benefits	14120	0	0	0	0
33)	Section 43.04 Services Assessment (OPWDD only)	14130	0	0	0	0
34)	Staff Development	14140	574	0	174	0
35)	Contracted Direct Care and Clinical Personal Services (from CFR-4A)	14150	5,250	0	1,490	0
36)	Supplies and Materials - Non-Household	14160	3,430	0	973	0
37)	Household Supplies	14170	280	0	79	0
38)	Telephone	14190	1,155	791	319	0
39)	Insurance - General	14260	900	0	256	0
40)	Other (Detail Required)	14998	550	32	156	0
41)	Total Other Than Personal Services (Sum Lines 21-40)	14999	17,687	1,053	4,967	0
EQUIPMENT - PROVIDER PAID						
42)	Lease/Rental Vehicle	15010	102	0	29	0
43)	Lease/Rental Equipment	15020	375	0	106	1,500
44)	Depreciation - Vehicle	15040	625	0	177	0
45)	Depreciation - Equipment	15050	677	30	192	0
46)	Interest - Vehicle	15070	250	0	16	0
47)	Other (Detail Required)	15998	950	0	270	0
48)	Total Equipment (Sum Lines 42-47)	15999	2,979	30	790	1,500
PROPERTY - PROVIDER PAID						
49)	Lease/Rental - Real Property	16010	21,000	1,038	5,960	0
50)	Leasehold/Leasehold Improvements	16020	250	0	142	0
51)	Depreciation - Building	16030	3,000	0	852	0
52)	Depreciation - Building/Land Improvements	16040	1,080	0	306	0

Funding State Agency:  
 OMH     SED  
 OPWDD  
 OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
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 PROGRAM/SITE  
 DATA

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

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1 9100 (YY) 1111910	2 9135 (YY) 1111913	3 9190 (YY) 1111919	4 9805 (YY) 1111980
53)	Mortgage/Cap Imprv Interest (Report MCFFA Bond Int. on Line 59)	16060	388	0	110	0
54)	Mortgage Expenses	16070	290	0	17	0
55)	Insurance - Property & Casualty	16080	250	198	71	0
56)	Real Estate Taxes	16090	1,020	0	289	0
57)	Interest on Capital Indebtedness	16100	1,044	0	296	0
58)	Start-Up Expenses	16110	100	0	28	0
59)	MCFFA/DASNY Interest Expense	16120	0	0	0	0
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	692	0	396	0
63)	Total Property-Provider Paid (Sum of Lines 49-62)	16999	29,114	1,236	8,467	0
TOTALS						
64)	Total Operating Costs (Sum lines 16,17,20,41 minus 29)	19010	412,184	59,878	52,821	0
65)	Agency Admin. Alloc.* (Line 64 times 0.097691)	19050	40,266	5,850	5,160	0
66)	Adjustments/Non-Allowable Costs (Detail Required)	19030	324	0	0	0
67)	Total Prog/Site Costs (Sum lines 29, 48, 63-65 minus 66)	19060	484,219	66,994	67,238	1,500
OPWDD 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:  
 OMH     SED  
 OPWDD  
 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 9100 (YY) 1111910	2 9135 (YY) 1111913	3 9190 (YY) 1111919	4 9805 (YY) 1111980
Program Code (Program Code Index)						
Program/Site Identification Number						
SECTION C: REVENUES						
69)	Participant Fee (Less SSI & SSA)	20010	0	0	0	0
70)	SSI and SSA	20020	0	0	0	0
71)	Home Relief/Public Assistance	20030	0	0	0	0
72)	Medicaid	20040	0	0	0	0
73)	Medicare	20060	0	0	0	0
74)	Other Third Parties (Detail Required)	20070	0	0	0	0
75)	OPWDD 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 OPWDD only)	22080	0	0	0	0
82)	Food Stamps (OASAS, OPWDD), Food Revenue (SED Only)	22160	0	0	0	0
83)	Gifts, Legacies, Bequests, Restricted Donations	22010	0	0	0	0
84)	Section 202/8/811 HUD Funds *	22020	0	0	0	0
85)	Interest/Dividend Income	22050	400	0	143	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 OPWDD programs, if this line is completed, complete Schedule OPWDD-3 (HUD Revenues and Expenses).  
 \*\* Refer to CFR manual for specific instructions.

Funding State Agency:  
 OMH     SED  
 OPWDD  
 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 9100 (YY) 1111910	2 9135 (YY) 1111913	3 9190 (YY) 1111919	4 9805 (YY) 1111980
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	409,717	61,955	72,965	0
93)	Net Deficit Funding (State & LGU Funding only)*	20110	0	0	0	0
94)	Other (Detail Required)	22998	25	0	9	1,500
95)	Gross Revenues (Sum Lines 69-94)	23999	410,142	61,955	73,117	1,500
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	410,142	61,955	73,117	1,500
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	0	0	0
104)	Other (Detail Required)	24080	0	0	0	0
105)	Total NON-GAAP Adjustments (Sum Lines 101-104)	24097	0	0	0	0
106)	TOTAL ADJ. TO REVENUE (Sum Lines 99 & 105)	24999	0	0	0	0
107)	TOTAL NET REVENUES (Line 95 minus 106)	25999	410,142	61,955	73,117	1,500

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

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

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
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SCHEDULE CFR-2  
 AGENCY FISCAL  
 SUMMARY

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

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 OPWDD TOTALS	5 SED TOTALS	6 SHARED PRG. TOTALS	7 OTHER PROGRAMS TOTALS*
EXPENSES									
1)	Personal Services (CFR-1, Line 16)	31999	5,691,168	0	997,127	0	391,742	0	4,302,299
2)	Vacation Leave Accruals (CFR-1, Line 17)	32999	175,544	0	2,842	0	7,063	0	165,639
3)	Fringe Benefits (CFR-1, Line 20)	33999	1,512,480	0	271,023	0	102,371	0	1,139,086
4)	OTPS (CFR-1, Line 41)	34999	1,759,456	0	241,565	0	23,707	0	1,494,184
5)	Equipment-Provider Paid (CFR-1, Line 48)	35999	233,073	0	4,115	0	5,299	0	223,659
6)	Property-Provider Paid (CFR-1, Line 63)	36999	924,179	0	109,775	0	38,817	0	775,587
7)	Net Agency Admin. (CFR-1, Line 65)	38050	892,763	0	147,763	0	51,276	0	693,724
8)	Adj./Non-Allow. Costs (CFR-1, Line 66)	38030	1,824	0	1,000	0	324	0	500
9)	Total Adj. Expenses (Sum Lines 1-7 minus 8)	38999	11,186,839	0	1,773,210	0	619,951	0	8,793,678
REVENUES									
10)	Gross Revenues (CFR-1, Line 95)	40999	11,463,045	0	1,790,057	0	546,714	0	9,126,274
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	11,463,045	0	1,790,057	0	546,714	0	9,126,274

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

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
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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	530,488	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	51,534	25)	Total Equipment (Sum Lines 19-24)	15996	16,339
4)	Non-Mandated Fringe Benefits	13301	89,664		PROPERTY - PROVIDER PAID		
5)	Total Fringe Benefits (Sum Lines 3-4)	13998	141,198	26)	Lease/Rental - Real Property	16011	40,726
	OTHER THAN PERSONAL SERVICES (OTPS)			27)	Leasehold/Leasehold Improvements	16021	0
6)	Audit/Legal	14200	21,713	28)	Depreciation - Building	16031	0
7)	Utilities	14210	16,931	29)	Depreciation - Building/Land Improvements	16050	0
8)	Telephone	14220	13,725	30)	Mortgage Interest	16061	0
9)	Repairs and Maintenance	14021	15,685	31)	Mortgage Expenses	16071	0
10)	Office Supplies and Postage	14161	21,971	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	56,369
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	135,856	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	892,763
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	892,763

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
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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	1,512,557	61)	OMH Adjusted Subtotal	19320	1,512,557
45)	OPWDD Subtotal	19130	0	62)	OPWDD Adjusted Subtotal	19330	0
46)	SED Subtotal	19140	524,883	63)	SED Adjusted Subtotal	19340	524,883
47)	Shared Programs Subtotal	19150	0	64)	Shared Programs Adjusted Subtotal	19350	0
48)	Other Programs Subtotal**	19160	7,101,208				
49)	Total Agency Operating Costs	19170	9,138,648				
CALCULATION OF RATIO VALUE FACTOR				CALCULATION OF ADJUSTED RATIO VALUE FACTOR *****			
50)	Net Agency Administration (CFR-3, Line 42)	19999	892,763	65)	OASAS Ratio Value Factor (line 53 divided by line 60)	19410	0.000000
51)	Total Agency Operating Costs (CFR-3, Line 49)	19171	9,138,648	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)	OPWDD 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	147,763				
55)	OPWDD Allocation (line 45 x line 52)	19230	0				
56)	SED Allocation (line 46 x line 52)	19240	51,276				
57)	Shared Programs Allocation (line 47 x line 52)	19250	0				
58)	Other Programs Allocation (line 48 x line 52)	19260	693,724				
59)	Total Agency Administration (sum lines 53 - 58)	19270	892,763				

\* 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, 0920, 1230, 1690, 1910, 2860, 2980, 6910, 6920, 8810 and programs with an "A" program code index (startup).  
 For OPWDD (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  
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NEW YORK STATE  
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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	131,014										
602	Assistant Executive Direct		X			2,080	1.000	120,001										
603	Comptroller/Controller		X			2,080	1.000	88,216										
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.      18,928      9.100      530,488

\* 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:  
 [ X ] OMH     [ ] SED  
 [ ] OPWDD  
 [ ] OASAS

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SCHEDULE CFR-4  
 PERSONAL  
 SERVICES

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

FTE'S MUST BE CALCULATED TO 3 DECIMAL PLACES.

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

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

Position Title	Appendix Code	COLUMN NUMBER	1			2			3			4					
			35	37.5	40	Other	Hours Paid	FTE	Amount Paid	Hours Paid	FTE	Amount Paid	Hours Paid	FTE	Amount Paid		
102 Housekeeping and Maintenance	X																
201 Mental Hygiene Worker (not			X			980	0.503	10,642	970	0.497	10,525	236	0.130	3,708			
203 Counselor (OMH CR only)				X										13,520	6.500	260,961	
205 Senior Counselor (OMH CR o	X													1,820	1.000	46,389	
205 Senior Counselor (OMH CR o			X											6,825	3.500	156,498	
206 Supervisor (OMH CR only)			X											1,950	1.000	55,333	
301 Case Manager			X											1,950	1.000	59,417	
318 Psychiatrist				X								1,301	0.625	121,466			
324 Social Worker, Licensed (L	X											3,812	2.095	118,820			
325 Social Worker Master's Lev	X											1,157	0.636	45,123			
343 Intake/Screening	X											460	0.253	9,605			
501 Program or Site Director	X											440	0.242	20,548			
501 Program or Site Director			X			970	0.497	11,695	980	0.503	11,818						
505 Office Worker	X											2,456	1.349	47,745			

Total "Hours Paid", "FTE" and "Amount Paid" for Positions.

\* Report Agency Administration in one column on a separate page.

\*\* For OASAS, program code = service level and program/site = PRU level.

Totals are transferred to Schedule CFR-1 Line 16 (Program/Site, Program Administration & LGU Administration), or Schedule CFR-3 Line 1 (Agency Administration).

Note: FTE's DO NOT get transferred.

Funding State Agency:  
 OMH     SED  
 OPWDD  
 OASAS

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SCHEDULE CFR-4  
 PERSONAL  
 SERVICES

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

FTE'S MUST BE CALCULATED TO 3 DECIMAL PLACES.

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

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

Appendix R	Position Title	35	Standard Work Week			Column 1		Column 2		Column 3		Column 4		Hours Paid	FTE	Amount Paid	
			37.5	40	Other	Hours Paid	FTE	Amount Paid	Hours Paid	FTE	Amount Paid	Hours Paid	FTE				Amount Paid
	505 Office Worker		X			75	0.038	650	75	0.038	651						
	590 Other Program Administrati	X										126	0.069	5,533			
Total "Hours Paid", "FTE" and "Amount Paid" for Positions.						2,025	1.038	22,987	2,025	1.038	22,994	9,988	5.399	372,548	26,065	13.000	578,598

\* 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  
 [ ] OPWDD  
 [ ] OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: July 1, 2010 TO June 30, 2011

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) [ X ] AGENCY ADMINISTRATION (Position Title Codes 600-699 series) [ ] \*

Appendix R	Position Title	35	Standard Work Week			1		2		3		4		Hours Paid	FTE	Amount Paid	
			37.5	40	Other	Hours Paid	FTE	Amount Paid	Hours Paid	FTE	Amount Paid	Hours Paid	FTE				Amount Paid
218	Teacher - Special Educati	X				4,841	2.660	122,185	1,406	0.773	40,740						
228	Teacher Aide	X				8,084	4.442	81,365									
322	Psychologist (Master's Lev	X									448	0.246	7,586				
333	Therapist - Occupational		X			44	0.023	832			12	0.006	236				
334	Therapist - Physical		X			1,754	0.899	44,166			498	0.255	12,535				
335	Therapist - Speech		X			1,916	0.983	40,000			544	0.279	11,353				
390	Other Clinical Staff/Assis			X							257	0.124	5,604				
501	Program or Site Director			X		906	0.436	19,747									
505	Office Worker	X							282	0.155	5,393						
Total "Hours Paid", "FTE" and "Amount Paid" for Positions.						17,545	9.443	308,295	1,688	0.928	46,133	1,759	0.910	37,314	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  
 [ ] OPWDD  
 [ ] OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: July 1, 2010 TO June 30, 2011

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		Hours Paid	Amount Paid
	PROGRAM CODE (PROGRAM CODE INDEX)	9100 (YY)	PROGRAM/SITE IDENTIFICATION NUMBER	1111910	9135 (YY)	1111913	9190 (YY)	1111919		
224 Teacher - Substitute									40	3,250
318 Psychiatrist									2	490
322 Psychologist (Master's Level)/Behavioral Specialis									10	600
335 Therapist - Speech									10	400

Total "Hours Paid" and "Amount Paid" for Positions. 70 5,250 0 0 22 1,490 0 0

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

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: July 1, 2010 TO June 30, 2011

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

SECTION A: NOTE: (OASAS and OPWDD 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, OPWDD 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 OPWDD 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.	24	2100 (00)/1111052	leased space	Any Agency Foundation	G	68,620	67,620	1,000

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.	24	2100 (00)/1111052	41,620	14,000	5,500	6,500	0	67,620

SECTION D: (This section applies only to OASAS and OPWDD 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: July 1, 2010 TO June 30, 2011

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 \$75,000 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	194,188	1.000	194,188	0	194,188	44,469	0
2. Mary Reynolds	601	131,014	1.000	131,014	0	131,014	27,503	1,200
3. Robert House	602	120,001	1.000	120,001	0	120,001	25,001	0
4. Lewis Knoxberry	603	88,216	1.000	88,216	0	88,216	19,554	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	71,885

5. Number of additional employees whose annualized salary and/or contracted payment amount is in excess of \$75,000: 0

\* 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  
 OPWDD  
 OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: July 1, 2010 TO June 30, 2011

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	Advocacy/Support Serv	Clinic Treatment	Community Residence,
2)	Program Code (Program Code Index)	00011	1760 (00)	2100 (00)	7050 (00)
UNITS OF SERVICE					
3)	OMH Units of Service	00121	1,305	5,621	2,508
4)	OPWDD Units of Service	00161	0	0	0
5)	OASAS Units of Service	00170	0	0	0
EXPENSES *					
6)	Personal Services	17010	45,981	372,548	578,598
7)	Vacation Leave Accruals	17020	845	685	1,312
8)	Fringe Benefits	17030	12,501	101,259	157,263
9)	Other Than Personal Services	17040	6,668	160,410	74,487
10)	Equipment - Provider Paid	17050	294	2,600	1,221
11)	Property - Provider Paid	17060	2,845	69,618	37,312
12)	Agency Administration	17080	6,448	62,024	79,292
13)	Adjustments/Non-Allowable Costs	17090	0	1000	0
14)	Total Adjusted Expenses (Lines 6-12 Minus 13)	17999	75,582	768,144	929,485
REVENUES *					
15)	Participant Fees (less SSI and SSA)	26010	0	19,786	0
16)	SSI and SSA	26020	0	0	69,505
17)	Home Relief/Public Assistance	26030	0	0	0
18)	Medicaid	26040	0	756,882	868,526
19)	Medicare	26060	0	68,626	0
20)	Other Third Parties	26070	0	1,278	0
21)	OPWDD 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:  
 OMH  
 OPWDD  
 OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: July 1, 2010 TO June 30, 2011

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	Advocacy/Support Serv	Clinic Treatment	Community Residence,
	Program Code (Program Code Index)	00011	1760 (00)	2100 (00)	7050 (00)
26)	State Grants (Detail Required)	26190	0	0	0
27)	LTSE Income Total (OMH and OPWDD only)	26220	0	0	0
28)	Food Stamps (OASAS, OPWDD)	26240	0	0	0
29)	Net Deficit Funding (State & LGU Funding only)*	26110	4,000	0	0
30)	Other (Detail Required)	26230	236	0	1,218
31)	Total Gross Revenues (Sum Lines 15-30)	26999	4,236	846,572	939,249
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	4,236	846,572	939,249
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	4,000	0	0
40)	Other (Detail Required)	27080	0	0	0
41)	Total NON-GAAP Adjustments (Sum Lines 37-40)	27998	4,000	0	0
42)	Subtotal Adj. to Revenue (Sum Lines 35 & 41)	27999	4,000	0	0
43)	Total Net Revenues (Line 31 Minus 42)	28999	236	846,572	939,249
44)	Net Operating Cost (Line 14 Minus 43)	29999	75,346	-78,428	-9,764

\* 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  
 OPWDD  
 OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: July 1, 2010 TO June 30, 2011

AGENCY NAME: Any Agency, Inc.  
 AGENCY CODE: 11110  
 COUNTY NAME & CODE: New York 31

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

TELEPHONE: 212 355-5555 Ext. 123\_\_\_

PLEASE CHECK: ESTIMATED CLAIM:  FINAL CLAIM:

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3
1) Accounting Method		Modified		Modified	Modified
2) State Contract Number/LGU Contract Number *		NEWYORK		NEWYORK	C008363
3) Program Type		Advocacy/Support Serv		Clinic Treatment	Community Residence,
4) Program Code (Program Code Index)		00012	1760 (00)	2100 (00)	7050 (00)
EXPENSES					
5) Personal Services		18010	45,981	372,548	578,598
6) Vacation Leave Accruals **		18020	845	685	1,312
7) Fringe Benefits		18030	12,501	101,259	157,263
8) Other Than Personal Services (OTPS)		18040	6,668	160,410	74,487
9) Equipment - Provider Paid ***		18050	6,006	5,569	5,995
10) Property - Provider Paid ****		18060	2,845	69,618	37,312
11) Agency Administration		18080	6,448	62,024	79,292
12) Adjustments/Non-Allowable Costs (Detail Required)		18090	0	1,000	0
13) Total Adjusted Expenses (Lines 5-11 Minus 12)		18999	81,294	771,113	934,259
REVENUES					
14) Participant Fees (less SSI & SSA)		46010	0	19,786	0
15) SSI & SSA		46020	0	0	69,505
16) Home Relief/Public Assistance		46030	0	0	0
17) Medicaid		46040	76,500	680,382	868,526
18) Medicare		46060	0	68,626	0
19) Other Third Parties		46070	0	1,278	0
20) OPWDD 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:

[ X ] OMH  
[ ] OPWDD  
[ ] OASAS

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: July 1, 2010 TO June 30, 2011

SCHEDULE DMH-2  
AID TO LOCALITIES/  
DIRECT CONTRACT  
SUMMARY

AGENCY NAME: Any Agency, Inc.  
AGENCY CODE: 11110  
COUNTY NAME & CODE: New York 31

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

TELEPHONE: 212 355-5555 Ext. 123\_\_\_

PLEASE CHECK: ESTIMATED CLAIM: [ ] FINAL CLAIM: [ X ]

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3
	Program Type	00072	Advocacy/Support Serv	Clinic Treatment	Community Residence,
	Program Code (Program Code Index)	00012	1760 (00)	2100 (00)	7050 (00)
25)	State Grants (Detail Required)	46190	0	0	0
26)	LTSE Income Total (OMH and OPWDD only)	46220	0	0	0
27)	Food Stamps (OASAS, OPWDD)	46240	0	0	0
28)	Net Deficit Funding (State & LGU Funding only)*	46110	4,000	0	0
29)	Other (Detail Required)	46230	236	1,500	1,218
30)	Total Gross Revenues (Sum Lines 14-29)	46999	80,736	771,572	939,249
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	80,736	771,572	939,249
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	4,000	0	0
39)	Other (Detail Required)	47080	0	0	4,990
40)	Total NON-GAAP Adjustments (Sum Lines 36-39)	47998	4,000	0	4,990
41)	Subtotal Adj. to Revenue (Sum Lines 34 & 40)	47999	4,000	0	4,990
42)	Total Net Revenues (Line 30 minus 41)	48999	76,736	771,572	934,259
43)	Net Operating Cost (Line 13 minus 42)	49999	4,558	-459	0
DEFICIT FUNDING					
44)	State Share	60010	4,000	0	0
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	4,000	0	0
48)	Non-Funded	60040	558	-459	0
49)	Total Deficit Funding (Sum Lines 47-48)	60999	4,558	-459	0

\* 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  
 OPWDD  
 OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: July 1, 2010 TO June 30, 2011

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

AGENCY NAME: Any Agency, Inc.  
 AGENCY CODE: 11110  
 COUNTY NAME & CODE: New York 31

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

TELEPHONE: 212 355-5555 Ext. 123\_\_\_

PLEASE CHECK: ESTIMATED CLAIM:  FINAL CLAIM:

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3	TOTAL
1) Accounting Method			Modified	Modified	Modified	
2) Program Type		00073	Advocacy/Support Serv	Clinic Treatment	Community Residence,	
3) Program Code (Program Code Index)		00013	1760 (00)	2100 (00)	7050 (00)	
4) Total Persons Served/Month		00220	100	262	8	
5) Total Units of Service		00999	1,305	4,839	2,508	
6) Gross Cost/Unit of Service		70999	62.29	159.35	372.51	
7) Net Cost/Unit of Service		71999	3.49	-0.09	0.00	
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	1,305			1,305
12) Total Adjusted Expenses		50999	80,736			80,736
13) Less Applied Net Revenue		61999	76,736			76,736
14) Net Operating Costs		62999	4,000			4,000
15) Contract Number (State/LGU)*		00201	NEWYORK			
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			2,508	2,508
19) Total Adjusted Expenses		50999			896,946	896,946
20) Less Applied Net Revenue		61999			896,946	896,946
21) Net Operating Costs		62999			0	0
22) Contract Number (State/LGU)*		00201			C008363	
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			C008363	

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

Funding State Agency:  
 OMH  
 OPWDD  
 OASAS

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: July 1, 2010 TO June 30, 2011

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

AGENCY NAME: Any Agency, Inc.  
 AGENCY CODE: 11110  
 COUNTY NAME & CODE: New York 31

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

TELEPHONE: 212 355-5555 Ext. 123\_\_\_

PLEASE CHECK: ESTIMATED CLAIM:  FINAL CLAIM:

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	1	2	3	TOTAL
1) Accounting Method		Modified		Modified	Modified	
2) Program Type		00073 Advocacy/Support Serv		Clinic Treatment	Community Residence,	
3) Program Code (Program Code Index)		00013 1760 (00)		2100 (00)	7050 (00)	
4) Total Persons Served/Month		00220	100	262	8	
5) Total Units of Service		00999	1,305	4,839	2,508	
6) Gross Cost/Unit of Service		70999	62.29	159.35	372.51	
7) Net Cost/Unit of Service		71999	3.49	-0.09	0.00	
8) Please Check:						
9) D FUNDING SOURCE CO (Non-Funded)   Index (OMH/OASAS)			090	090	090	
10) Number Persons Served/Month		00260	0	262	0	262
11) Number Units of Service		00250	0	4,839	0	4,839
12) Total Adjusted Expenses		50999	558	771,113	0	771,671
13) Less Applied Net Revenue		61999	0	771,572	0	771,572
14) Net Operating Costs		62999	558	-459	0	99
15) Contract Number (State/LGU)*		00201 NEWYORK		NEWYORK	C008363	
30) Total Adjusted Expenses		51999	81294	771113	934259	1,786,666
31) Less Net Revenue		63999	76736	771572	934259	1,782,567
32) Net Operating Costs		52999	4558	-459	0	4,099

\* 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: July 1, 2010 TO June 30, 2011

SCHEDULE SED-1  
 PROGRAM AND  
 ENROLLMENT DATA

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

Line No.	COLUMN NUMBER PROGRAM NAME	1 Preschool-Special Class over 2		2 Preschool-Sp Ed Itinerant Teac							
		PROGRAM CODE (PROGRAM CODE INDEX)	9100 (YY)	SCHOOL YEAR	9135 (YY)	SCHOOL YEAR	SUMMER	SCHOOL YEAR	SUMMER	SCHOOL YEAR	SUMMER
100	Non-disabled - UPK		0.000	0.000	0.000	0.000					
101	Non-disabled - Other		0.000	0.000	0.000	0.000					
102	Sec.4402 (Art.89) Sch. Dist. Placement		0.000	0.000	0.000	0.000					
103	Department of Health Chapter 428		0.000	0.000	0.000	0.000					
104	Sec.4408 (Art.89) Sch. Dist. Placement		0.000	0.000	0.000	0.000					
105	Sec.4410 (3-4 yr olds) Sch. Dist. Placement		19.681	21.351	5.000	4.250					
106	Local Social Services District		0.000	0.000	0.000	0.000					
107	Other		0.000	0.000	0.000	0.000					
108	Total by Funding Source (Sum Lines 102-107)		19.681	21.351	5.000	4.250					
109	Number of Days in Session		30	180	30	180					
110	Care Days (Line 108 times Line 109)		590	3,843	150	765					
115	Actual SEIS or SEIT Units Provided		0	0	593	1,695					
201	Approved Classroom Ratio		08:1:2.0	08:1:2.0							
202	Number of Classrooms		2.00	2.00	0.00	0.00					
203	Student FTE		14.520	15.451	0.000	0.000					
301	Approved Classroom Ratio		00:0:0.0	00:0:0.0							
302	Number of Classrooms		0.00	0.00	0.00	0.00					
303	Student FTE		0.000	0.000	0.000	0.000					
401	Approved Classroom Ratio		06:1:1.0	06:1:1.0							
402	Number of Classrooms		1.00	1.00	0.00	0.00					
403	Student FTE		5.161	5.900	0.000	0.000					
501	Approved Classroom Ratio										
502	Number of Classrooms		0.00	0.00	0.00	0.00					
503	Student FTE		0.000	0.000	0.000	0.000					
601	Approved Classroom Ratio										
602	Number of Classrooms		0.00	0.00	0.00	0.00					
603	Student FTE		0.000	0.000	0.000	0.000					
701	Approved Classroom Ratio										
702	Number of Classrooms		0.00	0.00	0.00	0.00					
703	Student FTE		0.000	0.000	0.000	0.000					
801	Approved Classroom Ratio										
802	Number of Classrooms		0.00	0.00	0.00	0.00					
803	Student FTE		0.000	0.000	0.000	0.000					
901	Approved Classroom Ratio										
902	Number of Classrooms		0.00	0.00	0.00	0.00					
903	Student FTE		0.000	0.000	0.000	0.000					
999	Total Student FTE		19.681	21.351	0.000	0.000					

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: July 1, 2010 TO June 30, 2011

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

Contact Person: Sally Sanders  
 Phone Number: 212 355-5555 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	0.983	30	25	2,615.80	2,200.00	547.00	2.00	274	2,473.50	2,175.00	83.1486
Physical Therapy	0.899	0	25	2,337.40	2,015.00	375.00	3.00	125	2,140.00	1,977.00	84.5812
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: July 1, 2010 TO June 30, 2011

RECONCILIATION

AGENCY CODE: 11110

AGENCY NAME: Any Agency, Inc.

Total agency expenses from Financial Statements	11,186,246	Total agency Revenues from Financial Statements	11,415,976
Additions:		Additions:	
Depreciation Variance	2,500	Prior Period Rate Adjustments	47,321
Total Additions:	2,500	Total Additions:	47,321
Subtractions:	0	Subtractions:	0
Total adjustments:	2,500	Total Adjustments:	47,321
Adjusted Financial Statement Expenses	11,188,746	Adjusted Financial Statement Revenues	11,463,297
Total agency Expenses from CFR-2, Col. 1, lines 8 + 9	11,188,663	Total agency Revenues from CFR-2, Col. 1, line 12	11,463,045
Difference	83	Difference	252

[ X ] OMH [ ] SED  
[ ] OPWDD  
[ ] OASAS

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
FOR THE PERIOD: July 1, 2010 TO June 30, 2011

WORKSHEET/OTHER  
DETAILS

PAGE 37

-----  
AGENCY CODE: 11110

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

SCHEDULE: CFR-1

PROGRAM: 1760 (00)  
SITE: 1111050

PROGRAM: 1760 (00)  
SITE: 1111276

PROGRAM: 2100 (00)  
SITE: 1111052

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 113

Line 39 Other Insurance 3,182  
Line 40 Data Processing 7,692  
Line 66 Line [49] - adjustment to lease 1,000  
Line 74 Other Third Parties 1,278

[ X ] OMH [ ] SED  
[ ] OPWDD  
[ ] OASAS

NEW YORK STATE  
CONSOLIDATED FISCAL REPORT  
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WORKSHEET/OTHER  
DETAILS

-----  
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  
[ ] OPWDD  
[ ] OASAS

NEW YORK STATE  
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WORKSHEET/OTHER  
DETAILS

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-----  
AGENCY CODE: 11110

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

SCHEDULE: CFR-1

PROGRAM: 9100 (YY)  
SITE: 1111910

PROGRAM: 9135 (YY)  
SITE: 1111913

PROGRAM: 9190 (YY)  
SITE: 1111919

Line 39 Other Insurance 900  
Line 40 Data Processing 200  
All Items <\$1,000 Each 350  
Line 47 All Items <\$1,000 Each 950  
Line 62 All Items <\$1,000 Each 692  
Line 66 Line [34] - other 324  
Line 94 All Items <\$1,000 Each 25

Line 40 Data Processing 15  
All Items <\$1,000 Each 17

Line 39 Other Insurance 256  
Line 40 Data Processing 66  
All Items <\$1,000 Each 90  
Line 47 All Items <\$1,000 Each 270  
Line 62 All Items <\$1,000 Each 396  
Line 94 All Items <\$1,000 Each 9

[ ] OMH [ X ] SED  
[ ] OPWDD  
[ ] OASAS

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WORKSHEET/OTHER  
DETAILS

-----  
AGENCY CODE: 11110

AGENCY NAME: Any Agency, Inc.

-----  
SCHEDULE: CFR-1

PROGRAM: 9805 (YY)  
SITE: 1111980

Line 94 Section 611/619 IDEA Money 1,500

OMH     SED  
 OPWDD  
 OASAS

NEW YORK STATE  
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WORKSHEET/OTHER  
DETAILS

-----  
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  
[ ] OPWDD  
[ ] OASAS

NEW YORK STATE  
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WORKSHEET/OTHER  
DETAILS

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-----  
AGENCY CODE: 11110

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

SCHEDULE: DMH-2

PROGRAM: 1760 (00)  
COUNTY: 31 - New York

PROGRAM: 2100 (00)  
COUNTY: 31 - New York

PROGRAM: 7050 (00)  
COUNTY: 31 - New York

Line 17 CSP 76,500  
Line 29 All Items <\$1,000 Each 236

Line 12 Adjustment to lease 1,000  
Line 17 Base Medicaid 604,853  
Level 1 COPS 75,529  
Line 19 Other Third Parties 1,278  
Line 29 Prior Year Level 1 COPS 1,500

Line 17 Base Medicaid 868,526  
Line 29 All Items <\$1,000 Each 1,218  
Line 39 OMH Share Medicaid CR Exempt Income 2,000  
Provider Share Medicaid CR Exempt I 2,990

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: July 1, 2010 to June 30, 2011*

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

Page \_\_\_\_\_

AGENCY NAME: Any Agency, Inc.

AGENCY CODE: 11110

Line No.	COLUMN NUMBER	1			2			3			4						
	PROGRAM CODE (PROGRAM CODE INDEX)	1760 (00)			1760 (00)			2100 (00)			7050 (00)			( )			
	PROGRAM TYPE	Advocacy/Support Services			Advocacy/Support Services			Clinic Treatment			Comm. Residence C&Y						
	PROG/SITE ID. #	1111050			1111276			1111052			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	N/A															
2	Collateral	N/A															
3	Group Collateral	N/A															
4	Crisis	N/A															
	<b>Intensive Psychiatric Rehab. (2320)</b>																
5	Regular	N/A															
	<b>Clinic Treatment (2100)</b>																
6	Service Days	1.00															
	<b>Continuing Day Treatment (1310)</b>																
7	Half Day	0.50															
8	Full Day	1.00															
	<b>PROS (6340) (7340) (8340)</b>																
9	PROS Units	1.00															
	<b>Day Treatment (0200)</b>																
	<b>Sheltered Workshop (0340)</b>																
	<b>On Site Rehabilitation (0320)</b>																
10	Brief Day	0.33															
11	Half Day	0.50															
12	Full Day	1.00															
13	Collateral	0.33															
14	All Other	1.00	632	632		673	673		5621	5621							
15	Residential (Patient Days)	1.00										2508	2508				
16	Total		632	632		673	673		5621	5621		2508	2508				

**NEW YORK STATE  
CONSOLIDATED FISCAL REPORT**

*For the Period: July 1, 2010 to June 30, 2011*

SCHEDULE OMH-2

MEDICAID  
UNITS OF SERVICE  
BY PROGRAM/SITE

Page \_\_\_\_\_

AGENCY NAME: \_\_\_\_\_ Any Agency \_\_\_\_\_  
AGENCY CODE: \_\_\_\_\_ 11110 \_\_\_\_\_

Line No.	COLUMN NUMBER		1			2			3			4					
	PROGRAM CODE (PROGRAM CODE INDEX)		1760 (00)			1760 (00)			2100 (00)			7050 (00)			( )		
PROGRAM TYPE		Advocacy/Support Services			Advocacy/Support Services			Clinic Treatment			Comm. Residence C&Y						
PROG/SITE ID. #		1111050			1111276			1111052			1111975						
		MEDICAID			MEDICAID			MEDICAID			MEDICAID			MEDICAID			
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
	Partial Hospitalization (2200)																
1	Regular	N/A															
2	Collateral	N/A															
3	Group Collateral	N/A															
4	Crisis	N/A															
	Intensive Psychiatric Rehab. (2320)																
5	Regular	N/A															
	Clinic Treatment (2100)																
6	Service Days	1.00															
	Continuing Day Treatment (1310)																
7	Half Day	0.50															
8	Full Day	1.00															
	PROS (6340) (7340) (8340)																
9	PROS Units	1.00															
	Day Treatment (0200)																
10	Brief Day	0.33															
11	Half Day	0.50															
12	Full Day	1.00															
13	Collateral	0.33															
14	All Other	1.00	0	0		0	0		4987	4987		2508	2508				
15	Residential (Patient Days)	1.00															
16	Total		0	0		0	0		4987	4987		2508	2508				

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: July 1, 2010 TO June 30, 2011

SCHEDULE OMH-3  
 CLIENT  
 INFORMATION

-----  
 AGENCY NAME: Any Agency, Inc.  
 AGENCY CODE: 11110

-----  

Line No.	COLUMN NUMBER	1	2	3	4
	PROGRAM CODE	1760 (00)	1760 (00)	2100 (00)	7050 (00)
	PROGRAM TYPE	Advocacy/Support Services	Advocacy/Support Services	Clinic Treatment	Community Residence, Childr
	PROG/SITE ID.#	1111050	1111276	1111052	1111975

PERSONS SERVED DURING THE YEAR

1) Persons on Rolls Beginning of Year	24	26	301	8
2) New Persons added to Rolls	26	24	64	1
3) Persons Removed from Rolls	24	26	103	1
4) Persons on Rolls, End of Year	26	24	262	8

NEW YORK STATE  
 CONSOLIDATED FISCAL REPORT  
 FOR THE PERIOD: July 1, 2010 TO June 30, 2011

-----  
 AGENCY NAME: Any Agency, Inc.  
 AGENCY CODE: 11110  
 -----

Line No.	COLUMN NUMBER PROGRAM CODE PROGRAM TYPE PROG/SITE ID.#	1 2100 (00) Clinic Treatment 1111052	TOTAL VISITS	REVENUE EARNED BY PAYOR
Payors:				
1)	Medicare Only		225	
2)	Medicaid Fee-for-Service Only		2,764	
3)	Medicaid Managed Care		843	
4)	Medicaid and Medicare		617	
5)	Medicaid Managed Care and Medicare			
6)	Medicaid and Other Private Insurance			
7)	Medicaid Managed Care and Other Private Insurance			
8)	Child Health Plus or Family Health Plus		280	19,320
9)	Other Private Insurance		562	
10)	Participant Fees- Co-pays and Deductibles			4,736
Uncompensated Care:				
11)	Participant Fees- Not Including Co-pays		301	15,050
12)	Third Party - Not Paid - Non-Covered Services		25	
13)	Third Party - Not Paid - Non-Eligible Licensed Staff			
14)	Third Party - Not Paid - Non-Eligible Out of Network			
15)	Total Visits (Sum of Lines 1-14)		5,617	
16)	Visits Eligible for Uncompensated Care Reimbursement (Sum Lines 11-14)		326	
17)	Uncompensated Care Visits (Line 16) as Percent of Total Visits (Line 15)		6	

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
 For the Period: July 1, 2010 to June 30, 2011

SCHEDULE OPWDD-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 Exclusively Purchased w/ Medicaid Card	Col. 2 Exclusively Purchased by ICF	Col. 3 ICF Purchases Made Only Where MA Card Did Not Cover Items	Col. 4 ICF Purchase Amount Associated w/ Col. 2 or 3	Line No.	SERVICE TYPE	Col. 1 Exclusively Purchased w/ Medicaid Card	Col. 2 Exclusively Purchased by ICF	Col. 3 ICF Purchases Made Only Where MA Card Did Not Cover Items	Col. 4 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					<b>Definitions and Notes:</b> <b>Consultation</b> - Practitioner provides training, oversight and direction to direct care staff. <b>Direct Service</b> - Practitioner directly treats the consumers. <b>Nursing</b> - Excludes medical services provided by a nurse practitioner.  *Other Medical Supplies: If Column 2 or 3 is checked, complete Schedule OPWDD-2 for each site as well. **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.					
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)										

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: July 1, 2010 to June 30, 2011*

**SCHEDULE OPWDD-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 OPWDD-1.  
 This schedule should show specifically which items of medical supplies are included or not included in the costs reported on Schedules CFR-1and OPWDD-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.

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: July 1, 2010 to June 30, 2011*

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

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

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

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

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

**NEW YORK STATE  
CONSOLIDATED FISCAL REPORT**  
For the Period: July 1, 2010 to June 30, 2011

SCHEDULE OPWDD-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.