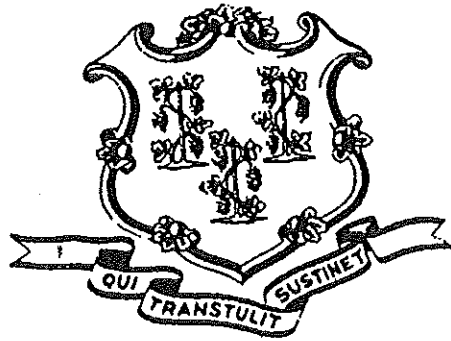


State of Connecticut



Annual Report of Residential and Day Services Department of Social Services and Department of Developmental Services Cost Year 2011

Parent Organization

Address (No. & Street, City, State, Zip Code)

Report for Year Beginning
July 1, 2010

Report for Year Ending
June 30, 2011

FEIN

DDS ID Number

#

For Department Use Only

Date Received	Number Assigned	Signed and Notarized

Organization Structure

Form of Organization:

Contact Personnel

<u>Name</u>	<u>Title</u>	<u>Address</u> (if different from Parent Organization)	<u>Telephone Number</u>
0	0		0
0	0		0

A copy of the current list of the full Board of Directors and members of the Executive Committee of the Board has been attached. Identify officers of the organization by their titles at the beginning of the list along with their addresses and telephone numbers.

Indicate if the information provided on this form has changed since the last operational report filing.

A copy of the most recent Chart of Organization has been attached. Identify any changes in management in the last year and attach a schedule explaining reason for the same.

Insurance

A copy of your most recent insurance certificate that lists "The State of Connecticut" as an additional insured is attached.

**Department of Social Services and Department of Developmental Services
 General Information**

Parent Organization #REF!	FEIN #REF!	Report for Year Ended #REF!	Page 2	of 31
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**Management Affidavit
 As to the Accuracy and Completeness of the Filing**

IT IS HEREBY CERTIFIED that I have reviewed this report and am familiar with the applicable regulations and operating guidelines governing its preparation. I have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware as a result of an inquiry or other research are properly disclosed as such in this report. To the best of my knowledge, under penalty of law, this filing represents accurate and complete information prepared from and reconciled to our books and records in accordance with instructions provided by the State of Connecticut, Department of Developmental Services and the Department of Social Services.

IT IS HEREBY CERTIFIED that all the supporting records for the revenues, expenses and statistics have been retained as required by the Department of Developmental Services and will be made available for audit in a timely manner and in a location specified by the Department of Developmental Services and/or Department of Social Services upon written request.

IT IS HEREBY CERTIFIED that our organization is in receipt of the Department of Developmental Services's guidelines on the handling of client funds and is in compliance with respect to the requirements for all client funds for which we are responsible.

IT IS HEREBY CERTIFIED that all withholdings from employees' paychecks have been processed in a timely fashion and payment made to the appropriate parties.

IT IS HEREBY CERTIFIED that the information reported on the RELATED PARTY DISCLOSURE form and attached worksheet(s), if applicable, are true and correct to the best of my knowledge. The related party information contained in the Related Party Disclosure has been reviewed for compliance to CLA Rate Setting Regulations, Section 17-313b-1(19) and the allowable cost reported for related party transactions have been limited to the cost to the related party and related party costs are reported in compliance with the Rate Setting Regulations Section 17-313b-3(5).

IT IS HEREBY CERTIFIED that the information reported on the ARMS-LENGTH LEASES form and attached worksheet(s), if applicable, are true and correct to my knowledge. Arms-Length leases are with individual or organizations that do not meet the definition of related party contained in Section 17-313b-1(19) of the CLA Rate Setting Regulations. Additionally, if requested by DDS, the parent organization agrees to file the documentation related to the lease.

SIGNATURE BY AUTHORIZED INDIVIDUAL AT THE PARENT ORGANIZATION OF:

Signature		Date	Title
Printed Name			Telephone Number
Subscribed and Sworn to before me	State of	Date	Signed (Notary Public)
Address of Notary Public			Date Commission Expires

(Notary Seal)

**Department of Social Services and Department of Developmental Services
 General Information**

Parent Organization	FEIN	Report for Year Ended 6/30/2011	Page 3	of 31
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**Certification by Independent Public Accountants
 Independent Auditor's Report**

We have audited the State of Connecticut Annual Report of Residential and Day Services, of _____ [provider name] as listed in the accompanying listing of Financial Schedules and Forms of _____ [provider name], as of, and for the year ending June 30, 2011. These financial schedules and forms are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial schedules and forms 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 schedules and forms are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial schedules and forms. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial schedules and forms. We believe that our audit provides a reasonable basis for our opinion.

The accompanying financial schedules and forms were prepared for the purpose of complying with the accounting and reporting practices specified in the State of Connecticut Department of Developmental Services/Department of Social Services Operating Manual for Parent Organizations Providing Residential and Day Programs and are not intended to be a complete set of financial statements.

In our opinion, the financial schedules and forms referred to above present fairly, in all material respects, the supplemental information of _____ [provider name], in conformity with accounting practices as specified in the State of Connecticut, Department of Developmental Services/Department of Social Services Operating Manual for Parent Organizations Providing Residential and Day Programs.

This report is intended solely for the information and use of the audit committee, Board of Directors, management, and state awarding agencies. This restriction is not intended to limit the distribution of this report, which is a matter of public record.

Signature	Date	Independent Public Accountant
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**Department of Social Services and Department of Developmental Services
 General Information**

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**Certification by Independent Public Accountants
 Compliance Statement**

We have audited the State of Connecticut Annual Report of Residential and Day Services of _____ [provider name], as of and for the year ended June 30, 2011, and have issued our report thereon dated _____. We conducted our audit in accordance with auditing standards generally accepted in the United States of America.

The management of _____ [provider name], is responsible for establishing and maintaining effective internal control over compliance with the requirements of the State of Connecticut, Department of Developmental Service's handling of client funds, Office of Policy and Management's Cost Standards, Department of Developmental Service's "Independent Contractor/Consultant Ethics Compliance Protocol", the Federal Regulations surrounding employee withholding taxes, and the reporting of related party transactions as defined in CLA Rate Setting Regulations Section 17-313b-1 (19) and Section 17-313b-3 (5).

In planning and performing our audit, we considered the internal control over compliance with requirements that could have a direct and material effect on a state program in order to determine our auditing procedures for purpose of expressing our opinion on compliance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of _____ [provider name] internal control over compliance.

A control deficiency in an entity's internal control over compliance exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect noncompliance with a type of compliance requirement of a state program on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects the entity's ability to administer a state program such that there is more than a remote likelihood that noncompliance with a type of compliance requirement of a state program that is more than inconsequential will not be prevented or detected by the entity's internal control.

A material weakness is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that material noncompliance with a type of compliance requirement of a state program will not be prevented or detected by _____ [provider name] internal control.

Our consideration of internal control over compliance was for the limited purpose described in the second paragraph and would not necessarily identify all deficiencies in internal control that might be significant deficiencies or material weaknesses. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above.

(Note - if applicable only) Our consideration of the internal control over compliance was for the limited purpose described in the second paragraph and would not necessarily identify all deficiencies in internal control that might be significant deficiencies or material weaknesses. We consider the deficiencies numbered _____ described in the accompanying schedule of findings and questioned costs, to be a significant deficiency and those numbered _____ and _____ to be material weaknesses in internal control over compliance.

This report is intended solely for the information and use of the audit committee, Board of Directors, management, and state awarding agencies. This restriction is not intended to limit the distribution of this report, which is a matter of public record.

Signature	Independent Public Accountant	Date
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**Department of Social Services and Department of Developmental Services
General Information**

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Certification by Independent Public Accountants

Listing of Financial Schedules and Forms

- * Administrative Expenses
- * Employee Benefits
- * Revenue and Expense Summary
- * Room and Board Costs For CLAs
- * Interest Expense Allocation
- * Allocation Worksheet
- ** Summary of Information CLA
- ** Summary of Information CRS
- ** Summary of Information Day
- ** Summary of Information IHS
- ** Summary of Information CTH
- ** Summary of Information Fee for Service
- ** Other
- ** ICF-MR
- ** Fair Rental Value (FRV) Calculations

Listing of General Information Schedules

- GI-3 Certification by Independent Public Accountant
- * GI-4 Related Party Disclosure
- * GI-5 Details to Leases
- * GI-6 Additional Disclosures
- * GI-7 Itemization of Donated capital Assets or Capital Acquisitions Purchased with Other Operating and/or Non Operating Revenue During the Fiscal Year
- * GI-8 Supplemental Disclosure Schedule if Executive director Salary Exceeds \$100,000

* Data required on these Schedules and Forms are Audited by the Independent Certified Public Accountant in conjunction with the preparation of Audited Financial Statements; verifications of positing and calculations may be required.

** These forms contain statistical (i.e., Client Census and Attendance) information as well as financial with regard to statistical, Agency's information systems for generating statistics have been reviewed, and audit with testing of statistical data have been performed to determine the reasonableness of statistics reported.

**Department of Social Services and Department of Developmental Services
 General Information**

Parent Organization	FEIN	Report for Year Ended	Page 5	of 31
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Related Party Disclosure

This Related Party Disclosure must be completed for the Annual Report of Residential and Day Services. If it is anticipated that additional "Related Party Transactions" will be entered into in subsequent fiscal period, the parent organization must file this form with the Annual Report of Residential and Day Services. "Related Parties" as defined in the CLA rate setting regulations Section 17-313b-1 (19) which states:

"RELATED PARTIES" MEANS PERSONS OR ORGANIZATIONS RELATED THROUGH MARRIAGE, ABILITY TO CONTROL, OWNERSHIP, FAMILY OR BUSINESS ASSOCIATION. PAST EXERCISE OR INFLUENCE OR CONTROL NEED NOT BE SHOWN, ONLY THE POTENTIAL OR ABILITY TO DIRECTLY OR INDIRECTLY EXERCISE INFLUENCE OR CONTROL.

"Related Party Transactions" can include but are not limited to:

- ⊗ Real Estate Sales or Leases.
- ⊗ Leasing for Vehicles, Office Equipment, Household Furnishings.
- ⊗ Mortgage Loans, Working Capital Loans.
- ⊗ Contracts for Management Services, Consultant Services, Professional Services (i.e., Attorneys, Accountants, etc.) or Other Material, Supplies or Services Purchased by the Agency.

Are there any related party transactions? Yes No If "Yes," the following information must be completed:

	<u>Related Party #1</u>	<u>Related Party #2</u>	<u>Related Party #3</u>
<u>Individual</u>			
Name	_____	_____	_____
Address	_____	_____	_____
City, Town, Zip	_____	_____	_____
<u>Individual's Firm/Business</u>			
Name	_____	_____	_____
Address	_____	_____	_____
City, Town, Zip	_____	_____	_____

Detailed description of services rendered: Page 6, Related Party Disclosure (attach a separate sheet, if necessary).

If services are shared by more than one residential or day program and/or mutually by the parent organization, allocation must be provided, on a separate worksheet attached to this schedule, with a full explanation of the basis of the allocations.

Complete pages 5 thru 7 for EACH related organization situation.

**Department of Social Services and Department of Developmental Services
 General Information**

Parent Organization	FEIN	Report for Year Ended	Page 6	of 31
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**Related Party Disclosure
 Related Party Real Estate Purchases and/or Mortgages**

Please provide a listing of real estate owned by the agency that involved a transaction with a related party as defined in Section 17-313b-1(19) of the CLA rate setting regulations.

<u>Property Address</u>	<u>Cost of Property</u>	<u>Unique ID</u>

Please provide a description of the relationship between the agency and related party.

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Complete this form for each real estate transaction that involves a related party.

**Department of Social Services and Department of Developmental Services
 General Information**

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**Supplemental Disclosure Schedule
 If Executive Director's Salary Exceeds \$100,000**

In accordance with Public Act 91-11,

"AN ACT CONCERNING CERTAIN DUTIES, SERVICES AND EXPENDITURES OF THE DEPARTMENT OF DEVELOPMENTAL SERVICES, THE DEPARTMENT OF HEALTH SERVICES AND THE COMMISSION ON HOSPITALS AND HEALTH CARE, AND CLARIFYING CERTAIN PROVISIONS OF THE LIVING WILL STATUTES"

Section 7, which states,

"IN DETERMINING THE AMOUNT OF PAYMENTS TO BE PAID BY THE STATE UNDER SECTION 17a-246 OF THE GENERAL STATUTES TO ANY ORGANIZATION OR FACILITY WHICH PROVIDES EMPLOYMENT OPPORTUNITIES OR DAY SERVICES, OR SERVICES IN A RESIDENTIAL FACILITY, FOR PERSONS REFERRED BY THE DEPARTMENT OF MENTAL RETARDATION, MENTAL HEALTH OR HUMAN SERVICES, OR ANY OTHER STATE AGENCY, THE TOTAL COST ALLOWANCE FOR THE SALARY OF THE DIRECTOR OF SUCH ORGANIZATION OR FACILITY SHALL NOT EXCEED [SEVENTY-FIVE THOUSAND DOLLARS] ONE HUNDRED THOUSAND DOLLARS, EXCEPT THAT AFTER JULY 1, 2007, AND ANNUALLY THEREAFTER, THE COST ALLOWANCE FOR THE SALARY OF THE DIRECTOR MAY BE INCREASED BY AN AMOUNT NOT TO EXCEED THE PERCENTAGE INCREASE OF ANY COST OF LIVING INCREASE PROVIDED UNDER THE TERMS OF THE CONTRACT OF THE ORGANIZATION"

List below the Executive Director's Salary and the sources of funding if it is in excess of \$100,000:

Executive Director's Name and Salary:	
\$ Funded by DDS	
\$ Funded by Other State Agency(s):	
\$ Funded by Non-State Agency(s):	
Total	

**Department of Social Services and Department of Developmental Services
 General Information**

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**Detail to Existing and/or Proposed Leases
 "Arms-Length Leases"**

Disclosure of the requested information is required for property and movable equipment "Arms-Length" leases. Arms-Length leases are with individual or organizations that do not meet the definition of related party contained in Section 17-313b-1(19) of the CLA Rate Setting Regulations. The related party criteria contained in the regulations includes relationships established through: marriage, ability to control, ownership, family or business association. Section 17-313b-1(19) should be reviewed for compliance.

Description of Items Leased	Name of Lessor	Address of Lessor	Date of Lease	Unique ID	Lease Expense Reported on		Buy Out Provision Yes / No
					Page/Line Number	Cost	

Note: Please include copies of any newly acquired lease for items listed above.

**Department of Social Services and Department of Developmental Services
 General Information**

Parent Organization		FEIN	Report for Year Ended	Page of
			10	31
Contracted Administrative and Management Services				
Firm Name	Address	Type of Service*	Description of Service	Total Fee for Service
*Type of service: accounting, legal, management, etc.				
Pending Litigation				
Are there any lawsuits pending against your organization? If "Yes," include estimated date of settlement, potential financial impact, legal address and telephone number.				

Page 13 - Interest Expense & Allocation Worksheet

	Total	Total Interest Expense	Total Unaccounted
1. Building and Land Improvements	\$ -	\$ -	
2. Fixed Equipment	\$ -	\$ -	
3. Movable Equipment			
a. Transportation and Vehicle Expense	\$ -	\$ -	
b. Other Movable Equipment	\$ -	\$ -	
c. Total Movable Equipment (3a + 3b)	\$ -	\$ -	\$ -
4. Working Capital Interest	\$ -	\$ -	
5. Percent of Total Interest Expense			
6. Total Interest Expense	\$ -	\$ -	\$ -
7. Total Interest Expense Excluding Transportation, Vehicle and	\$ -	\$ -	\$ -

	Total Allowable A&G/Bene fit Costs	Total Allocated A&G	Total Allocated Employee Benefits	Total Unaccounted
1. Allocation for Administration	#REF!	\$ 50	#REF!	\$ 50
a. Amount of Allocation	#REF!	\$ 50	#REF!	\$ 50
b. Percent of Administration Total	#REF!	#REF!	#REF!	#REF!
2. Benefits Costs Allocated to Program				
a. Amount of Allocation	\$ -	\$ -	\$ -	\$ -
b. Percent of Benefit Allocation			-100.00%	

Page 14 - Administrative and General Expenses

		FTEs	A&G
1.	Salaries & Wages		
a-	Administration		
b-	Business		
c-	Secretarial/Clerical		
d-	Other (Specify, see A&G Schedule)		\$ -
e-	Total Salary & Wages (a thru d)		\$ -
2.	Non-Salary		
a-	Accounting & Auditing		
b-	Legal Fees		
c-	Office Supplies (including postage)		
d-	Occupancy Costs (utilities, telephone, repairs, rent, taxes)		
e-	Dues & Membership Fees		
f-	Management Services		
g-	Consultant Services		
h-	Data Processing		
i-	Staff Development & Seminars		
j-	Temporary Help (Non-Payroll)		
k-	Depreciation & Amortization		
l-	Insurance		
m-	Employee Mileage		
n-	Vehicle Cost		
o-	Lease Equipment & Maintenance		
p-	Other (Specify, see A&G Schedule)		\$ -
q-	Total Non-Salary (2a-2p)		\$ -
3.	Subtotal Administration Salary & Wages and Non-Salary (1e + 2q)		\$ -
4.	Allocated Employee Benefits		\$ -
5.	Allocated Interest Expense		\$ -
6.	Non-Reimbursable Costs that are directly related to this Cost Center		
a-	Entertainment		
b-	Fines & Penalties		
c-	Bad Debts & Cost of Action to collect receivables		
d-	Taxes (except for payroll, use & property)		
e-	Advertising (except for recruitment of personnel)		
f-	Contingency Reserves		
g-	Legal, accounting & professional services incurred to represent agency in actions involving government		
h-	Medical & Dental Service which can be covered by Title 19		
i-	Costs substituted by the fair rental allowance in the room & board calculation		
j-	Amortization of Goodwill		
k-	Depreciation on Donated Capital Assets on reported page 11		
l-	Fund Raising & Cost associated with donations		
m-	Start-up Costs for CLA not yet opened		
n-	Unallowable Related Party Costs		
o-	Executive Director Salary in excess of \$100,000		#REF!
p-	Lobbying Costs		
q-	Unallowable Cost per DDS Accounting Standards		
r-	Other (Specify, see A&G Schedule)		\$ -
s-	Total Non-Reimbursable Costs that are directly related to this Cost Center (6a thru 6r)		#REF!
7.	Other Operating and Non-Operating Revenue (Expense Recoveries that are directly related to this Cost Center)		
8.	Total Deductions to Administrative and General Costs (6s + 7)		#REF!
9.	Total Direct Allowable Administrative (3 + 5)		\$ -
10.	Total Allowable Administrative (3 + 4 + 5 + 8)		#REF!

		CLA Total	
1. Licensed Bed Capacity			
a.	Total number of Licensed Beds in the home		
b.	Total number of DDS Funded Beds included in 1a		
c.	Total number of Respite Beds included in 1a		
d.	Total Number of Non-DDS Funded Beds included in 1a		
2. Days Calculations			
a.	Number of Days Facility Open		
b.	Potential Participant Days for Licensed Beds (2a * 1a)		
c.	Potential Participant Days for Licensed Respite Beds (2a * 1c)		
d.	Potential Participant Days for Non-DDS Funded Beds (2a * 1d)		
e.	Total Potential Days for DDS Contract Service Authorizations		
3. Client Days			
a.	Total number of actual DDS participant days in the home		
b.	Total number of actual Non-DDS Funded participant days		
c.	Total number of actual days present for Licensed Respite Beds		
d.	Leave Days with Family		
e.	Medical Leave Days		
	1. Hospital		
	2. Skilled Nursing Facility		
	3. ICF/MR		
f.	Other Leave Days		
g.	Total Client Days (3a thru 3f)		
4. Percentage of Utilization			
a.	Non-Respite Beds		
b.	Respite Beds		
c.	DDS Contract Service Authorizations		
5. FTEs			
a.	Direct Staff		
	1. House Managers		
	2. House Supervisors		
	3. Direct Care Staff		
	4. Per Diem / Substitute Staff		
	5. RN - Direct Care Only		
	6. LPN - Direct Care Only		
	7. Clinical Staff - Direct Care Only		
	8. Other (Specify, see CLA Schedule)		
	9. Total Direct Staff FTEs (5a1 thru 5a8)		
b.	Allocated Staff		
	1. Residential Director / Program Managers		
	2. Program Supervisors		
	3. RN - Health Service Coordination		
	4. LPN - Health Service Coordination		
	5. Clinical Staff		
	6. Other (Specify, see CLA Schedule)		
	7. Total Allocated Staff FTEs (5b1 thru 5b6)		
c.	Total FTEs (5a + 5b)		

		CLA Total	
6	Salaries & Wages		
a	Direct Staff		
	1. House Managers	\$ -	
	2. House Supervisors	\$ -	
	3. Direct Care Staff	\$ -	
	4. Per Diem / Substitute Staff	\$ -	
	5. RN - Direct Care Only	\$ -	
	6. LPN - Direct Care Only	\$ -	
	7. Clinical Staff - Direct Care Only	\$ -	
	8. Other (Specify, see CLA Schedule)	\$ -	\$ -
	9. Total Direct Staff Salary (6a1 thru 6a8)	\$ -	\$ -
b	Allocated Staff		
	1. Residential Director / Program Managers	\$ -	
	2. Program Supervisors	\$ -	
	3. RN - Health Service Coordination	\$ -	
	4. LPN - Health Service Coordination	\$ -	
	5. Clinical Staff	\$ -	
	6. Other (Specify, see CLA Schedule)	\$ -	\$ -
	7. Total Allocated Staff Salary (6b1 thru 6b6)	\$ -	\$ -
c	Total Salaries & Wages (6a + 6b)	\$ -	\$ -
7	Non-Salary		
a	Contract Personnel		
	1. Occupational, Physical, and Speech Therapy	\$ -	
	2. Nurse	\$ -	
	3. Behaviorist and Psychology	\$ -	
	4. Psychiatry	\$ -	
	5. Other (Specify, see CLA Schedule)	\$ -	\$ -
	6. Total Non-Salary Contract Personnel (7a1 thru 7a5)	\$ -	\$ -
b	Supplies and Services		
	1. General Supplies & Services	\$ -	
	2. Employee Training, Fees and Supplies	\$ -	
	3. Client Med. & Education & Recreation	\$ -	
	4. Amortization Start-up	\$ -	
	5. Total Supplies and Services (7b1 thru 7b4)	\$ -	\$ -
c	Transportation		
	1. Transportation (excluding Vehicle Interest)	\$ -	
	2. Vehicle Interest	\$ -	
	3. Total Transportation (7c1 + 7c2)	\$ -	\$ -
d	1. Other (Specify, see CLA Schedule)	\$ -	\$ -
	2. Start Up Costs for Opening a new CLA	\$ -	
e	Total Non-Salary (7a6 + 7b5 + 7c3 + 7d)	\$ -	\$ -
8	Interest (except for CLA)	\$ -	
9	Employee Benefits	#REF!	\$ -
10	Administrative & General	#REF!	\$ 50
11	Total Direct Service Costs	#REF!	\$ 50
12	a. Non-Reimbursable Costs	\$ -	
	b. Start Up Costs for Opening a new CLA	\$ -	\$ -
13	Other Operating & Non-Operating Revenue	\$ -	
14	Total Cost of CLA	#REF!	\$ 50
15	Total Direct Service Costs Excluding Employee Benefit and A&G	\$ -	\$ -
16	Revenue for Non-DDS Participants	\$ -	
17	Revenue for Licensed Respite Participants	\$ -	
18	Revenue for Vendor Service Authorizations	\$ -	
19	Per Diem Based on Actual Costs of Contract Service Authorizations	\$ -	
20	Cost for DDS Contract Service Authorizations	#REF!	\$ 50

		CRS Total	#REF!	#REF!
1. Total Openings				
a.	Total number of Contract Service Authorizations			
b.	Total number of Non-DDS Funded Participants			
c.	Total Openings (a + b)			
2. Days Calculations				
a.	Number of Days Facility Open			
b.	Potential Client Days (1c * 2a)			
c.	Total Potential Days for DDS Contract Service Authorizations			
3. Client Days				
a.	Total number of actual DDS participant days in the home			
b.	Total number of actual Non-DDS Funded participant days			
c.	Total Client Days (a + b)			
4. Percentage of Utilization				
a.	DDS Contract Service Authorizations (3a / 2c)			
b.	Total CRS Utilization (3c / 2b)			
5. FTEs				
a.	Direct Staff			
	1. House Managers			
	2. House Supervisors			
	3. Direct Care Staff			
	4. Per Diem / Substitute Staff			
	5. RN - Direct Care Only			
	6. LPN - Direct Care Only			
	7. Clinical Staff - Direct Care Only			
	8. Other (Specify, see CRS Schedule)			
	9. Total Direct Staff FTEs (5a1 thru 5a8)			
b.	Allocated Staff			
	1. Residential Director / Program Managers			
	2. Program Supervisors			
	3. RN - Health Service Coordination			
	4. LPN - Health Service Coordination			
	5. Clinical Staff			
	6. Other (Specify, see CRS Schedule)			
	7. Total Allocated Staff FTEs (5b1 thru 5b6)			
c.	Total FTEs (5a + 5b)			

		CRS Total	#REF!	#REF!
		VALUE!	VALUE!	VALUE!
6	Salaries & Wages			
a	Direct Staff			
	1. House Managers	\$ -		
	2. House Supervisors	\$ -		
	3. Direct Care Staff	\$ -		
	4. Per Diem / Substitute Staff	\$ -		
	5. RN - Direct Care Only	\$ -		
	6. LPN - Direct Care Only	\$ -		
	7. Clinical Staff - Direct Care Only	\$ -		
	8. Other (Specify, see CRS Schedule)	\$ -	\$ -	\$ -
	9. Total Direct Staff Salary (6a1 thru 6a8)	\$ -	\$ -	\$ -
b	Allocated Staff			
	1. Residential Director / Program Managers	\$ -		
	2. Program Supervisors	\$ -		
	3. RN - Health Service Coordination	\$ -		
	4. LPN - Health Service Coordination	\$ -		
	5. Clinical Staff	\$ -		
	6. Other (Specify, see CRS Schedule)	\$ -	\$ -	\$ -
	7. Total Allocated Staff Salary (6b1 thru 6b6)	\$ -	\$ -	\$ -
c	Total Salaries & Wages (6a + 6b)	\$ -	\$ -	\$ -
7	Non-Salary			
a	Contract Personnel			
	1. Occupational, Physical, and Speech Therapy	\$ -		
	2. Nurse	\$ -		
	3. Behaviorist and Psychology	\$ -		
	4. Psychiatry	\$ -		
	5. Other (Specify, see CRS Schedule)	\$ -	\$ -	\$ -
	6. Total Non-Salary Contract Personnel (7a1 thru 7a5)	\$ -	\$ -	\$ -
b	Supplies and Services			
	1. General Supplies & Services	\$ -		
	2. Employee Training, Fees and Supplies	\$ -		
	3. Client Med. & Education & Recreation	\$ -		
	4. Amortization Start-up	\$ -		
	5. Total Supplies and Services (7b1 thru 7b4)	\$ -	\$ -	\$ -
c	Transportation			
	1. Transportation (excluding Vehicle Interest)	\$ -		
	2. Vehicle Interest	\$ -		
	3. Total Transportation (7c1 + 7c2)	\$ -	\$ -	\$ -
d	1. Other (Specify, see CRS Schedule)	\$ -	\$ -	\$ -
	2. Start Up Costs for Opening a new CRS	\$ -		
e	Total Non-Salary (7a6 + 7b5 + 7c3 + 7d)	\$ -	\$ -	\$ -
8	Interest	\$ -		
9	Employee Benefits	#REF!	\$ -	#REF!
10	Administrative & General	#REF!	\$ 50	#REF!
11	Total Direct Service Costs	#REF!	\$ 50	#REF!
12	a. Non-Reimbursable Costs	\$ -		
	b. Start Up Costs for Opening a new CRS	\$ -	\$ -	\$ -
13	Other Operating & Non-Operating Revenue	\$ -		
14	Total Cost of CRS	#REF!	\$ 50	#REF!
15	Total Direct Service Costs Excluding Employee Benefit and A&G	\$ -	\$ -	\$ -
16	Revenue for Non-DDS Participants	\$ -		
17	Revenue for VSA Participants	\$ -		
18	Per Diem Based on Actual Costs of Contract Service Authorizations		#VALUE!	#VALUE!
19	Cost for DDS Contract Service Authorizations	#REF!	\$ 50	#REF!

		IHS Total	#REF!	#REF!
1. Total Openings				
a.	Total number of Contract Service Authorizations			
b.	Total number of Vendor Service Authorizations			
c.	Total number of Non-DDS Participants			
d.	Total Openings (a + b + c)			
2. Percentage of Utilization				
a.	Total number of Potential billable units			
b.	Total number of Actual units			
c.	Percent Utilization (b / a)			
3. FTEs				
a.	Direct Staff			
	1. House Managers			
	2. House Supervisors			
	3. Direct Care Staff			
	4. Per Diem / Substitute Staff			
	5. RN - Health Service Coordinator			
	6. LPN - Health Service Coordinator			
	7. Clinical Staff			
	8. Other (Specify, see IHS Schedule)			
	Total Direct Staff FTEs (3a1 thru 3a8)			
b.	Allocated Staff			
	1. Residential Director / Program Managers			
	2. Program Supervisors			
	3. RN - Coordination Only			
	4. LPN - Coordination Only			
	5. Clinical Staff			
	6. Other (Specify, see IHS Schedule)			
	Total Allocated Staff FTEs (3b1 thru 3b6)			
c.	Total FTEs (3a + 3b)			
4. Salaries & Wages				
a.	Direct Staff			
	1. House Managers	\$ -		
	2. House Supervisors	\$ -		
	3. Direct Care Staff	\$ -		
	4. Per Diem / Substitute Staff	\$ -		
	5. RN - Health Service Coordinator	\$ -		
	6. LPN - Health Service Coordinator			
	7. Clinical Staff			
	8. Other (Specify, see IHS Schedule)	\$ -	\$ -	\$ -
	Total Direct Staff Salary (4a1 thru 4a8)	\$ -	\$ -	\$ -

		IHS-Total	#REF!	#REF!
			#REF!	#REF!
4.	Salaries & Wages continued			
b.	Allocated Staff			
	1. Residential Director / Program Managers	\$ -		
	2. Program Supervisors	\$ -		
	3. RN - Health Service Coordination	\$ -		
	4. LPN - Health Service Coordination	\$ -		
	5. Clinical Staff	\$ -		
	6. Other (Specify, see IHS Schedule)	\$ -	\$ -	\$ -
	7. Total Allocated Staff Salary (4b1 thru 4b6)	\$ -	\$ -	\$ -
c.	Total Salaries & Wages	\$ -	\$ -	\$ -
5.	Non-Salary			
a.	Contract Personnel			
	1. Occupational, Physical, and Speech Therapy	\$ -		
	2. Nurse	\$ -		
	3. Behaviorist and Psychology	\$ -		
	4. Psychiatry	\$ -		
	5. Other (Specify, see IHS Schedule)	\$ -	\$ -	\$ -
	6. Total Non-Salary Contract Personnel (5a1 thru 5a5)	\$ -	\$ -	\$ -
b.	Supplies and Services			
	1. General Supplies & Services	\$ -		
	2. Employee Training, Fees and Supplies	\$ -		
	3. Client Med. & Education & Recreation	\$ -		
	4. Amortization Start-up	\$ -		
	5. Total Supplies and Services (7b1 thru 7b4)	\$ -	\$ -	\$ -
c.	Transportation			
	1. Transportation (excluding Vehicle Interest)	\$ -		
	2. Vehicle Interest	\$ -		
	3. Total Transportation (7c1 + 7c2)	\$ -	\$ -	\$ -
d.	Other (Specify, see IHS Schedule)	\$ -	\$ -	\$ -
e.	Total Non-Salary (5a6 + 5b5 + 5c3 + 5d)	\$ -	\$ -	\$ -
6.	Interest for IHS	\$ -		
7.	Employee Benefits	#REF!	#REF!	#REF!
8.	Administrative & General	#REF!	#REF!	#REF!
9.	Total Direct Service Costs	#REF!	#REF!	#REF!
10.	Non-Reimbursable Costs	\$ -		
11.	Other Operating & Non-Operating Revenue	\$ -		
12.	Total Cost of IHS	#REF!	#REF!	#REF!
13.	Total Direct Service Costs Excluding Employee Benefit and A&G	\$ -	\$ -	\$ -
14.	Revenue for Vendor Service Authorizations	\$ -		
15.	Revenue for Non-DDS Participants	\$ -		
16.	Cost for DDS Contract Service Authorizations	#REF!	#REF!	#REF!

IHS Schedule			
Description	#REF	#REF	#REF
This schedule has been left un-protected so that new lines can be added. Be sure to adjust the Print Area and page margins so that the schedule prints correctly when using the Print Manager.			
Page 19 Line 348 - FTEs - Other Direct Staff (click to return to Summary IHS)			
Total			

Page 19 Line 366 - FTEs - Other Allocated Staff (click to return to Summary IHS)			
Description			
Total			

Page 19 Line 418 - Salaries and Wages - Other Direct Staff (click to return to Summary IHS)			
Description			
Total			

Page 20 Line 465 - Salaries and Wages - Other Allocated Staff (click to return to Summary IHS)			
Description			
Total			

Page 20 Line 525 - Non-Salary - Other Contract Personnel (click to return to Summary IHS (2))			
Description			
Total			

Page 20 Line 541 - Non-Salary - Other (click to return to Summary IHS (2))			
Description			
Total			

		CTH Total	#REF	#REF
1. Total Openings				
a.	Total number of Contract Service Authorizations			
b.	Total number of Vendor Service Authorizations			
c.	Total number of Non-DDS Participants			
d.	Total Openings (a + b + c)			
2. Percentage of Utilization				
a.	Total number of Potential billable units			
b.	Total number of Actual units			
c.	Percent Utilization (b / a)			
3. FTEs				
a.	Direct Staff			
	1. House Managers			
	2. House Supervisors			
	3. Direct Care Staff			
	4. Per Diem / Substitute Staff			
	5. RN - Health Service Coordinator			
	6. LPN - Health Service Coordinator			
	7. Clinical Staff			
	8. Other (Specify, see CTH Schedule)			
	Total Direct Staff FTEs (3a1 thru 3a8)			
b.	Allocated Staff			
	1. Residential Director / Program Managers			
	2. Program Supervisors			
	3. RN - Coordination Only			
	4. LPN - Coordination Only			
	5. Clinical Staff			
	6. Other (Specify, see CTH Schedule)			
	Total Allocated Staff FTEs (3b1 thru 3b6)			
c.	Total FTEs (3a + 3b)			
4. Salaries & Wages				
a.	Direct Staff			
	1. House Managers	\$ -		
	2. House Supervisors	\$ -		
	3. Direct Care Staff	\$ -		
	4. Per Diem / Substitute Staff	\$ -		
	5. RN - Health Service Coordinator	\$ -		
	6. LPN - Health Service Coordinator	\$ -		
	7. Clinical Staff	\$ -		
	8. Other (Specify, see CTH Schedule)	\$ -	\$ -	\$ -
	Total Direct Staff Salary (4a1 thru 4a8)	\$ -	\$ -	\$ -

		CTH-Total	#REF!	#REF!
4.	Salaries & Wages continued			
b.	Allocated Staff			
	1. Residential Directory / Program Managers	\$ -		
	2. Program Supervisors	\$ -		
	3. RN - Health Service Coordination	\$ -		
	4. LPN - Health Service Coordination	\$ -		
	5. Clinical Staff	\$ -		
	6. Other (Specify, see CTH Schedule)	\$ -	\$ -	\$ -
	7. Total Allocated Staff Salary (4b1 thru 4b6)	\$ -	\$ -	\$ -
c.	Total Salaries & Wages	\$ -	\$ -	\$ -
5.	Non-Salary			
a.	Contract Personnel			
	1. Occupational, Physical, and Speech Therapy	\$ -		
	2. Nurse	\$ -		
	3. Behaviorist and Psychology	\$ -		
	4. Psychiatry	\$ -		
	5. Other (Specify, see CTH Schedule)	\$ -	\$ -	\$ -
	6. Total Non-Salary Contract Personnel (5a1 thru 5a5)	\$ -	\$ -	\$ -
b.	Supplies and Services			
	1. General Supplies & Services	\$ -		
	2. Employee Training, Fees and Supplies	\$ -		
	3. Client Med. & Education & Recreation	\$ -		
	4. Amortization Start-up	\$ -		
	5. Total Supplies and Services (7b1 thru 7b4)	\$ -	\$ -	\$ -
c.	Transportation			
	1. Transportation (excluding Vehicle Interest)	\$ -		
	2. Vehicle Interest	\$ -		
	3. Total Transportation (7c1 + 7c2)	\$ -		
d.	Other (Specify, see CTH Schedule)	\$ -	\$ -	\$ -
e.	Total Non-Salary (5a6 + 5b5 + 5c3 + 5d)	\$ -	\$ -	\$ -
6.	Interest for CTH	\$ -		
7.	Employee Benefits	\$ -		
8.	Administrative & General	\$ -		
9.	Total Direct Service Costs	\$ -		
10.	Non-Reimbursable Costs	\$ -		
11.	Other Operating & Non-Operating Revenue	\$ -		
12.	Total Cost of CTH	\$ -		
13.	Total Direct Service Costs Excluding Employee Benefit and A&G	\$ -	\$ -	\$ -
14.	Revenue for Vendor Service Authorizations	\$ -		
15.	Revenue for Non-DDS Participants	\$ -		
16.	Cost for DDS Contract Service Authorizations	\$ -		

		Agency Total	#REF!	#REF!
1.	Total Openings			
a.	Total number of Contract Service Authorizations			
b.	Total number of Vendor Service Authorizations			
c.	Total number of Non-DDS participants			
d.	Total Openings (a + b + c)			
2.	Percentage of Utilization			
a.	Total number of Potential billable units			
b.	Total number of Actual units			
c.	Percent Utilization (b / a)			
3.	FTEs			
a.	Direct Staff			
	1. House Managers			
	2. House Supervisors			
	3. Direct Care Staff			
	4. Per Diem / Substitute Staff			
	5. RN - Direct Care Only			
	6. LPN - Direct Care Only			
	7. Clinical Staff - Direct Care Only			
	8. Other (Specify, see Day Schedule)			
	9. Total Direct Staff FTEs (3a1 thru 3a8)			
b.	Allocated Staff			
	1. Residential Director / Program Managers			
	2. Program Supervisors			
	3. RN - Nursing Coordination Only			
	4. LPN - Nursing Coordination Only			
	5. Clinical Staff			
	6. Other (Specify, see Day Schedule)			
	7. Total Allocated Staff FTEs (3b1 thru 3b6)			
c.	Total FTEs			
4.	Salaries & Wages			
a.	Direct Staff			
	1. House Managers	\$ -		
	2. House Supervisors	\$ -		
	3. Direct Care Staff	\$ -		
	4. Per Diem / Substitute Staff	\$ -		
	5. RN - Direct Care Only	\$ -		
	6. LPN - Direct Care Only	\$ -		
	7. Clinical Staff - Direct Care Only	\$ -		
	8. Other (Specify, see Day Schedule)	\$ -	\$ -	\$ -
	9. Total Direct Staff Salary (4a1 thru 4a8)	\$ -	\$ -	\$ -
b.	Allocated Staff			
	1. Residential Director / Program Managers	\$ -		
	2. Program Supervisors	\$ -		
	3. RN - Nursing Coordination Only	\$ -		
	4. LPN - Nursing Coordination Only	\$ -		
	5. Clinical Staff	\$ -		
	6. Other (Specify, see Day Schedule)	\$ -	\$ -	\$ -
	7. Total Allocated Staff Salary (4b1 thru 4b6)	\$ -	\$ -	\$ -
c.	Total Salaries & Wages	\$ -	\$ -	\$ -

		Agency Total	#REF!	#REF!
5.	Non-Salary			
a.	Contract Personnel			
	1. Occupational, Physical and Speech Therapy	\$ -		
	2. Nurse	\$ -		
	3. Behaviorist and Psychology	\$ -		
	4. Psychiatry	\$ -		
	5. Other (Specify, see Day Schedule)	\$ -	\$ -	\$ -
	6. Total Non-Salary (5a1 thru 5a5)	\$ -	\$ -	\$ -
b.	Supplies and Services			
	1. General Supplies and Services	\$ -		
	2. Employee Training, Fees and Supplies	\$ -		
	3. Client Wages and Benefits	\$ -		
	4. Total Supplies and Services (5b1 thru 5b3)	\$ -	\$ -	\$ -
c.	Transportation			
	1. Transportation (excluding Vehicle Interest)	\$ -		
	2. Vehicle Interest	\$ -		
	3. Total Transportation (5c1 + 5c2)	\$ -	\$ -	\$ -
d.	Plant Operations and Maintenance			
	1. Building Costs	\$ -		
	2. Equipment Costs, Depreciation and Rent	\$ -		
	3. Interest Costs			
	A. Building and Land Improvements	\$ -		
	B. Fixed Equipment	\$ -		
	C. Other Movable Equipment	\$ -		
	D. Total Interest Costs (3A thru 3C)	\$ -	\$ -	\$ -
	4. Utilities, Insurance, Maintenance and Other	\$ -		
	5. Total Plant Operations and Maintenance (5d1 thru 5d4)	\$ -	\$ -	\$ -
e.	Other (Specify, see Day Schedule)	\$ -	\$ -	\$ -
f.	Total Non-Salary	\$ -	\$ -	\$ -
6.	Total Direct Service Costs	\$ -	\$ -	\$ -
7.	Program Costs			
a.	Employee Benefits	\$ -		
b.	Administrative and General	\$ -		
c.	Working Capital Interest	\$ -		
d.	Total Program Costs (7a thru 7c)	\$ -		
8.	Less Non-Reimbursable Cost	\$ -		
9.	Sales Revenue Net of Sales Revenue Allowances	\$ -		
10.	Less Other Operating and Non-Operating Revenue	\$ -		
11.	Total Cost of Day Program	\$ -	\$ -	\$ -
12.	Total Direct Service Costs Excluding Employee Benefit and A&G	\$ -	\$ -	\$ -
13.	Revenue for Vendor Service Authorizations	\$ -		
14.	Revenue for Non-DDS Participants	\$ -		
15.	Cost for DDS Contract Service Authorizations	\$ -	\$ -	\$ -

Day Schedule

This schedule has been left un-protected so that new lines can be added. Be sure to adjust the Print Area and page margins so that the schedule prints correctly when using the Print Manager.

Page 23, Line 338 - FTEs - Other Direct Staff
(click to return to Summary Day)

Description	#REF	#REF	#REF	#REF
Total				

Page 23, Line 336 - FTEs - Other Allocated Staff
(click to return to Summary Day)

Description	#REF	#REF	#REF	#REF
Total				

Page 23, Line 438 - Salaries and Wages - Other Direct Staff
(click to return to Summary Day)

Description	#REF	#REF	#REF	#REF
Total				

Page 23, Line 436 - Salaries and Wages - Other Allocated Staff
(click to return to Summary Day)

Description	#REF	#REF	#REF	#REF
Total				

Page 24, Line 535 - Non-Salary - Other Contract Personnel
(click to return to Summary Day (2))

Description	#REF	#REF	#REF	#REF
Total				

Page 24, Line 53 - Non-Salary - Other Contract Personnel
(click to return to Summary Day (2))

Description	#REF	#REF	#REF	#REF
Total				

	ICF Agency Total	#REF!	Other Agency Total	#REF!
1. Total Client Openings				
2. Number Days Operating In Year				
3. Salaries and Wages	\$ -		\$ -	
4. FTES				
5. Non-Salary	\$ -		\$ -	
6. Employee Benefits			\$ -	
7. Administrative and General Allocation			\$ -	
8. Interest Expense			\$ -	
9. Less Operating and Non-Operating Revenue	\$ -		\$ -	
10. Total Cost	\$ -	\$ -	\$ -	\$ -
11. Direct Services Costs Excluding Employee Benefit and Administrative and General	\$ -	\$ -	\$ -	\$ -

Page 26 - Summary Fee for Service

1	Total Clients Served	
2	Salaries & Wages	
a.	Managers	
b.	Supervisors	
c.	Instructor/Job Coach	
d.	Clinical Staff	
e.	Transportation	
f.	Other (Specify, see Fee for Service Schedule)	\$ -
g.	Total Salaries & Wages (2a thru 2f)	\$ -
3	FTEs	
a.	Managers	
b.	Supervisors	
c.	Instructor/Job Coach	
d.	Clinical Staff	
e.	Transportation	
f.	Other (Specify, see Fee for Service Schedule)	
g.	Total FTEs (3a thru 3f)	
4	Non-Salary	
a.	Consultants	
b.	Supplies & Services	
c.	Transportation	
d.	Plant Operations & Maintenance (<i>Day Only</i>)	
e.	Other (Specify, see Fee for Service Schedule)	\$ -
f.	Total Non-Salary (4a thru 4e)	\$ -
5	Employee Benefits	
6	Administrative and General Allocation	
7	Interest Expense	
8	Less Sales Revenue	
9	Less Operating and Non-Operating Revenue	
10	Total Cost	\$ -
11	Direct Services Costs Excluding Employee Benefit and A&G	

Page 27 - Summary Employee

		Total
1.	Social Security (FICA)	
2.	Unemployment	
3.	Workers Compensation	
4.	Insurance (Health, Dental, Disability, Life)	
5.	Retirement	
6.	Other (Specify, see Employee Schedule)	\$ -
7.	Less Benefits Included in Room & Board Maintenance Salaries	
8.	Total Benefits (1 thru 7)	\$ -
9.	Salary	
a.	Administrative and General	\$ -
b.	CLA/CRS/ISH/CTH	\$ -
c.	Day Program	\$ -
d.	ICF/Other	\$ -
e.	Fee for Service	\$ -
f.	Total Salaries (9a thru 9e)	\$ -
10.	FTE'S	
a.	Administrative and General	
b.	CLA/CRS/ISH/CTH	
c.	Day Program	
d.	ICF/Other	
e.	Fee for Service	
f.	Total FTE's (10a thru 10e)	
11.	Benefits (as % of Total Salary Dollars) (8/9f)	

		R&B Total
1.	Real Property Depreciation	\$ -
2.	Rental Payments on Leased Single Unit Structures	\$ -
a.	CIL Rent or Mortgage Payment *	\$ -
b.	All Other Rental Payments	\$ -
c.	Total Rental (2a + 2b)	\$ -
3.	Interest on Real Property	\$ -
4.	Less Non-Reimbursable and Other Costs (e.g. HUD Subsidies and Revenue Offsets) (see Room & Board Schedule)	\$ -
5.	Net Actual Property Costs (1 + 2c + 3 - 4)	\$ -
6.	Percentage of Square Footage Used for A&G Activities	\$ -
7.	Prorated Portion of Actual Costs (5 - (5 x 6))	\$ -
8.	Approved Property Costs	\$ -
a.	CHFA	\$ -
b.	Recognition of Actual Debt Service	\$ -
c.	Rental Payments Approved by DSS	\$ -
d.	Total Approved Property (8a + 8b + 8c)	\$ -
9.	Movable Equipment Depreciation (excluding Motor Vehicles)	\$ -
10.	Rental Payments on Leased Real Estate in Multi-Unit Building Structures	\$ -
11.	Property and Real Estate Taxes (excluding Motor Vehicles)	\$ -
12.	Interest on Movable Equipment (excluding Motor Vehicles)	\$ -
13.	Interest on Working Capital	\$ -

* The higher of CIL Rent (at line 2a.) or CIL Interest and CIL Depreciation (at lines 1 and 3) may be reported.

		R&B Total
14.	Insurance (Property and 1/3 General Liability Only)	\$ -
15.	Support Supplies and Services	
a.	Dietary	
	1. Food and Kitchen Supplies	\$ -
	2. Dining and Ordering Out	\$ -
b.	Housekeeping Supplies	\$ -
c.	Laundry	\$ -
d.	Plant Maintenance, Operations and Repairs	\$ -
e.	Utilities	
	1. Heat	\$ -
	2. Light & Power	\$ -
	3. Water & Sewer	\$ -
	4. Cable	\$ -
f.	5. Other (see Room & Board Schedule)	\$ -
	Equip. Under \$2,500/Equip. Rental/Other	\$ -
	(see Room & Board Schedule)	\$ -
g.	Maintenance Salaries and Benefits	\$ -
h.	Maintenance Cost Funded through Debt Reserve	\$ -
i.	Total Support Supplies and Services (15a thru 15h)	\$ -
16.	HUD Audit Fees	\$ -
17.	Subtotal Room and Board Expenses (9 thru 14 + 15 + 16)	\$ -
18.	Less Other Operating and Non-Operating	\$ -
a.	Revenue (not included in Line 4, see Room & Board Schedule)	\$ -
b.	Less Interest Income	\$ -
19.	Subtotal of Net Expenses (17 - 18)	\$ -
20.	Actual and Imputed Client Days	
a.	Days open per year	
b.	Total openings	
c.	Imputed 90% occupancy	
21.	Total Direct R&B Cost (4 + 7 + 8d + 17)	\$ -

		Amount
1.	Operating Revenue	
a.	Service for Community Living Arrangements	
b.	Service for Continuous Residential Supports	
c.	Service for Individualized Home Supports	
d.	Service for CTH Support	
e.	Service for Day Programs	
f.	Temporary Service Supplement	
g.	Start Up Funding for a new CLA/CRS	
h.	Respite	
i.	Individual Support	
j.	Birth to Three	
k.	ICF/MRs	
l.	Room & Board for Community Living Arrangements	
m.	Room & Board for Children	
n.	Other State Agencies	
o.	Non-DDS Participant Revenue (Specify, see Revenue Schedule)	\$ -
p.	Tuition-Public / Private Schools	
q.	HUD Rental Subsidies	
r.	Other Programs	
s.	DDS Cost Settlements	
t.	Vendor Service Authorization Revenue (Fiscal Intermediaries) (Specify, see Revenue Schedule)	\$ -
u.	Total Operating Revenue (1a thru 1t)	\$ -
2.	Other Non-Operating Revenue	
a.	Grant Revenues	
b.	Sales Revenue from Day Programs (Specify, see Revenue Schedule)	\$ -
c.	Total Other Non-Operating Revenue (2a + 2b)	\$ -
d.	Other Revenue	
	1. Fund Raising / Contributions	
	A. Restricted (Specify, see Revenue Schedule)	\$ -
	B. Unrestricted	
	2. Membership Dues	
	3. Investment / Interest Income	
	A. Restricted (Specify, see Revenue Schedule)	\$ -
	B. Unrestricted	
	4. Management Contract Services	
	5. Other (Specify, see Revenue Schedule)	\$ -
	6. Total Other Revenue (2d1 thru 2d5)	\$ -
e.	Total Other Non-Operating Revenue (2a + 2b + 2d6)	\$ -
3.	Total Revenue (1 + 2c)	\$ -
4.	Expenses	
a.	Direct Costs Allowable R&B	\$ -
b.	Total Direct Service Costs	
	1. Residential	
	A. CLA	\$ -
	B. CRS	\$ -
	C. IHS	\$ -
	D. CTH	\$ -
	E. Total Residential Direct Service Costs (4b1A thru 4b1D)	\$ -
	2. Day	\$ -
	3. Other	\$ -
	4. Fee for Service	\$ -
	5. Total Direct Service Costs (4b1E + 4b2 + 4b3 + 4b4)	\$ -
c.	Total Expenses (4a + 4b5)	\$ -
d.	Total Employee Benefits	\$ -
e.	Total Administration	\$ -
f.	Total Gross Expenses	\$ -
5.	Net Excess / Deficiency	\$ -

Revenue Schedule

This schedule has been left un-protected so that new lines can be added. Be sure to adjust the Print Area and page margins so that the schedule prints correctly when using the Print Manager.

Page 30, Line 10 - Non-DDS Participant Revenue (click to return to Statement Revenue)

# of Non-DDS Participants	Program in which Non-DDS Participant Revenue is recorded	Cost Center in which Non-DDS Participant Revenue is recorded	Amount
Total			\$

Page 30, Line 11 - Vendor Service Authorization Revenue (click to return to Statement Revenue)

# of Vendor Service Authorizations	Program in which Vendor Service Authorization Revenue is recorded	Cost Center in which Vendor Service Authorization Revenue is recorded	Amount
Total			\$

Page 30, Line 2b - Sales Revenue from Day Programs (click to return to Statement Revenue)

Type of Sales Revenue	Program in which Sales Revenue is recorded	Cost Center in which Sales Revenue is recorded	Amount
Total			\$

Page 30, Line 2d 1A - Restricted Other Revenue (click to return to Statement Revenue)

Donor	Restriction Purpose	Amount
Total		\$

Page 30, Line 2d 3A - Restricted Investment/Revenue (click to return to Statement Revenue)

Institution	Explanation of Interest/Revenue	Amount
Total		\$

Page 30, Line 2d 5 - Other Revenue (click to return to Statement Revenue)

Institution	Explanation of Interest/Revenue	Amount
Total		\$

Error Check

Result	Support Ref#	Error Check
Fail	1	Administrative and General Allocated
PASS	2	Employee Benefits Allocated
PASS	3	FTE's reported on the Administrative and General Worksheet
PASS	4	CLA Non-DDS Participant Revenue
PASS	4	CLA Vendor Service Authorization Revenue
PASS	4	CRS Non-DDS Participant Revenue
PASS	4	CRS Vendor Service Authorization Revenue
PASS	4	IHS Non-DDS Participant Revenue
PASS	4	IHS Vendor Service Authorization Revenue
PASS	4	CTH Non-DDS Participant Revenue
PASS	4	CTH Vendor Service Authorization Revenue
PASS	4	Day Non-DDS Participant Revenue
PASS	4	Day Vendor Service Authorization Revenue
PASS	4	Day Sales Revenue
Warning	5	Day Client Wages compared to Day Sales Revenue
PASS	4	Fee for Service Sales Revenue

Administrative and General Allocated		
Total Allowed A&G (Page 14 Line 10)	Total Allocated A&G Page 13, Line 1a (Column E, Line 20)	Total Unallocated Amount #REF!
#REF!	\$ 50	

Employee Benefits Allocated		
Total Employee Benefits (Page 25 Line 8)	Total Allocated Employee Benefits Page 13, Line 2a (Column F, Line 23)	Total Unallocated Amount \$
\$	\$	

FTEs reported on the Administrative and General Worksite			
	FTEs	A&G	Commitment
Administration	0.00	\$	Good
Business Secretarial/Clerical	0.00	\$	Good
Other	0.00	\$	Good

Revenue has been imputed according to Revenue Schedule									
	Revenue identified as being generated by the Summary CLA (2) Page 16 Lines 16, 18	Revenue identified as being generated by the CLA Program on the Revenue Schedule	Revenue identified as being generated by the CRS Program on the Revenue Schedule	Revenue identified as being generated by the IHS Program on the Revenue Schedule	Revenue identified as being generated by the CTH Program on the Revenue Schedule	Revenue identified as being generated by the CTH Program on the Revenue Schedule	Revenue identified as being generated by the Day Program on the Revenue Schedule	Revenue identified as being generated by the Service Fee Program on the Revenue Schedule	Revenue identified as being generated by the Fee for Service Program on the Revenue Schedule
Non-DDS Vendor Sales Revenue	\$	\$	\$	\$	\$	\$	\$	\$	\$

Client Wages and Benefits		Difference of Sales Revenue to Client
Client Wages and Benefits Page 22 Line 5b3	Sales Revenue Page 22 Line 9	
\$	\$	\$

**Department of Social Services and Department of Developmental Services
 Reconciliation**

Parent Organization	FEIN	Report for Year Ended
1. Residential Costs per Annual Report of Residential and Day Services (From Summary CLA, line 14)		
2. Residential Costs per Annual Report of Residential and Day Services (From Summary CRS, line 14)		
3. Residential Costs per Annual Report of Residential and Day Services (From Summary IHS, line 12)		
4. Residential Costs per Annual Report of Residential and Day Services (From Summary CTH, line 12)		\$ -
5. Day Costs per Annual Report of Residential and Day Services (From Summary Day, line 11)		\$ -
6. Room & Board Costs per Annual Report of Residential and Day Services (From Room & Board Costs for CLAs, line 21)		\$ -
7. ICF and Other Costs per Annual Report of Residential and Day Services (From Summary ICF and Other, line 10)		\$ -
8. Fee for Service Costs per Annual Report of Residential and Day Services (From Summary Fee for Service, Line 9)		
9. Subtotal Costs per Annual Report of Residential and Day Services (1 thru 8)		\$ -
10. Add Back all Expense Recoveries and Non-Reimbursables		
a. From Administrative and General, line 6s (Non-Reimbursables)		
b. From Administrative and General, line 7 (Other Operating & Non-Operating Revenue)		\$ -
c. From Summary CLA, line 12 (Non-Reimbursable Cost)		\$ -
d. From Summary CLA, line 13 (Other Operating & Non-Operating Revenue)		\$ -
e. From Summary CRS, line 12 (Non-Reimbursable Cost)		\$ -
f. From Summary CRS, line 13 (Other Operating & Non-Operating Revenue)		\$ -
g. From Summary IHS, line 10 (Non-Reimbursable Cost)		\$ -
h. From Summary IHS, line 11 (Other Operating & Non-Operating Revenue)		\$ -
i. From Summary CTH, line 10 (Non-Reimbursable Cost)		\$ -
j. From Summary CTH, line 11 (Other Operating & Non-Operating Revenue)		\$ -
k. From Summary DAY, line 8 (Less Non-Reimbursable Cost)		\$ -
l. From Summary DAY, line 9 (Sales Revenue)		\$ -
m. From Summary DAY, line 10 (Less Other Operating & Non-Operating Revenue)		\$ -
n. From Summary ICF and Other, Line 9 (Less Other Operating & Non-Operating Revenue)		\$ -
o. From Summary Fee for Service Sales Revenue, line 8 (Sales Revenue)		\$ -
p. From Summary Fee for Service, Line 9 (Less Operating & Non-Operating Revenue)		\$ -
q. Total Expense Recoveries & Non-Reimbursables (lines 10a thru 10p)		
11. Adjusted Costs Per Annual Report of Residential and Day Services (line 9 + 10q)		
12. Total Expenses Per Financial Statements		
13. Difference/Reconciling Items (12 - 11)		
Explain below, use additional sheet(s) if necessary:		

Total difference		\$ -

PREPARER IDENTIFICATION:	EXECUTIVE DIRECTOR APPROVAL:
_____	_____
Print or Type Name	Print or Type Name
_____	_____
Title	Title
_____	_____
Telephone Number	Telephone Number

**Department of Social Services and Department of Developmental Services
Amended Affidavit**

Parent Organization	FEIN	Report for Year Ended
<p>It is hereby certified that I have reviewed the changes highlighted in this amended report. I certify that the only changes made to the report have been highlighted. I understand and agree with any and all financial implications that resulted from these changes.</p>		
Signature (Authorized Official)	Date Signed	