

OASAS
 OPWDD

NEW YORK STATE
CONSOLIDATED FISCAL REPORTING SYSTEM

SCHEDULE CQR-1

AGENCY QUARTERLY
FISCAL SUMMARY

Consolidated Quarterly Report
Fiscal Period: 07/01/11 - 06/30/12

QUARTER REPORTED (Please Check):

___ 1st ___ 2nd ___ 3rd ___ Mid-Year ___ Final REVISION # ___

Page ___

AGENCY NAME: _____ AGENCY CODE: _____ LGU: _____
PREPARED BY: _____ COUNTY NAME AND CODE: _____ () LGU APPROVAL BY: _____
TELEPHONE: _____

USE WHOLE DOLLARS ONLY

Line No.	COLUMN NUMBER	1	2	3	4		5		6		7	
					PROGRAM TYPE ()	PROGRAM TYPE ()	PROGRAM TYPE ()	PROGRAM TYPE ()	CODE	INDEX	CODE	INDEX
	ITEM DESCRIPTION	STATE AGENCY APPROVED BUDGET	SERVICE PROVIDER YEAR-TO-DATE TOTAL	SERVICE PROVIDER TOTAL FOR THIS QUARTER								
	ACCOUNTING METHOD →											
	EXPENSES											
1	Personal Services											
2	Vacation Leave Accruals											
3	Fringe Benefits											
4	Other Than Personal Services											
5	Equipment-Provider Paid											
6	Property-Provider Paid											
7	Agency Administration											
8	Adjustments/Non-Allowable Costs											
9	Total Expenses (Lines 1-7 minus 8)											
	REVENUES											
10	Please Check if Participant Specific Revenue Methodology is Used (OPWDD Only) → → → → → →											
11	Medicaid Revenue											
12	Non-Medicaid Revenue											
13	Total Revenues (Lines 11-12)											
14	NET OPERATING COSTS (Line 9 minus 13)											

MISCELLANEOUS												
15	State Contract Number / LGU Contract Number *											
16	Total Persons Served (OMH Only)											
17	Total Units of Service											
18	Gross Cost Per Unit											
19	Net Cost Per Unit											
20	Workshop Contract Sales (Direct)											
21	Local Government (OASAS Only)											
22	Voluntary Contributions (OASAS Only)											

* For direct contracts enter the State contract number. For local county contract enter the local county contract number.

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 Fiscal Period: 07/01/10 - 06/30/11

QUARTER REPORTED (Please Check):

____ 1st ____ 2nd ____ 3rd ____ Mid-Year REVISION # ____

Page ____

AGENCY NAME: _____ AGENCY CODE: _____ LGU: _____
 PREPARED BY: _____ COUNTY NAME AND CODE: _____ () LGU APPROVAL BY: _____
 TELEPHONE: _____

USE WHOLE DOLLARS ONLY

Line No.	ITEM DESCRIPTION	1 STATE AGENCY APPROVED BUDGET	2 SERVICE PROVIDER YEAR-TO-DATE TOTAL	3 SERVICE PROVIDER TOTAL FOR THIS QUARTER	4 PROGRAM TYPE ()		5 PROGRAM TYPE ()		6 PROGRAM TYPE ()		7 PROGRAM TYPE ()	
					CODE	INDEX	CODE	INDEX	CODE	INDEX	CODE	INDEX
23	A. Funding Code											
24	Direct Contract # (If Applicable)											
25	Local Contract # (If Applicable)											
26	No. Persons Served (OMH Only)											
27	Units of Service											
28	Total Expenses											
29	Revenue:Medicaid											
30	Revenue:Other											
31	Total Revenues											
32	Net Operating Costs											
33	B. Funding Code											
34	Direct Contract # (If Applicable)											
35	Local Contract # (If Applicable)											
36	No. Persons Served (OMH Only)											
37	Units of Service											
38	Total Expenses											
39	Revenue:Medicaid											
40	Revenue:Other											
41	Total Revenues											
42	Net Operating Costs											
43	C. Funding Code											
44	Direct Contract # (If Applicable)											
45	Local Contract # (If Applicable)											
46	No. Persons Served (OMH Only)											
47	Units of Service											
48	Total Expenses											
49	Revenue:Medicaid											
50	Revenue:Other											
51	Total Revenues											
52	Net Operating Costs											
53	D. Funding Code											
54	Direct Contract # (If Applicable)											
55	Local Contract # (If Applicable)											
56	No. Persons Served (OMH Only)											
57	Units of Service											
58	Total Expenses											
59	Revenue:Medicaid											
60	Revenue:Other											
61	Total Revenues											
62	Net Operating Costs											