

**SAMPLE**

PROGRAM NAME  
 FOSTER CARE  
 STATEMENT OF REVENUES AND EXPENDITURES  
 FOR THE FISCAL YEAR ENDED \_\_\_\_\_

(1 of 6)  
STATEMENT OF REVENUES AND EXPENDITURES

	FOSTER BOARDING HOME	EMERGENCY FOSTER BOARDING HOME	AGENCY OPERATED BOARDING HOME	AGENCY OPERATED BOARDING HOME	INSTITUTION	GROUP HOME	GROUP RESIDENCE	TOTAL
<b>REVENUES:</b>								
Fee for Service using NYC Approved Rates (Note _____)	\$	\$	\$	\$	\$	\$	\$	\$
Applied Income and In-Kind Contribution								
Other Income								
<b>TOTAL REVENUES</b>								
<b>EXPENDITURES</b>								
Administrative Costs								
Other Than Administrative Costs								
Pass Through								
<b>TOTAL EXPENDITURES</b>								
(Less) Questioned Costs								
<b>TOTAL ALLOWABLE COSTS</b>								
(Deficiency)/Excess of Revenue Over Expense	\$	\$	\$	\$	\$	\$	\$	\$

STATEMENT OF DETAILED EXPENDITURES  
FOR THE FISCAL YEAR ENDED \_\_\_\_\_

	FOSTER BOARDING HOME	EMERGENCY FOSTER BOARDING HOME	AGENCY OPERATED BOARDING HOME	AGENCY OPERATED BOARDING HOME	INSTITUTION	GROUP HOME	GROUP RESIDENCE	TOTAL
<u>PERSONNEL COSTS:</u>								
Administration	\$	\$	\$	\$	\$	\$	\$	\$
Social Service								
Child Care								
Child Support								
Maintenance								
TOTAL SALARIES								
Fringe Benefits								
TOTAL PERSONNEL COSTS								
<u>OTHER OPERATING COSTS</u>								
Purchase of Services								
Food								
Utilities/Fuel								
Telephone								
Office Supplies								
Audit/Legal								
Insurance								
Depreciation								
Other Costs								
TOTAL OPERATING COSTS								
TOTAL COSTS AS REPORTED (PSS 2652)								
(Less) Applied Income Allowable Expenses As Reported								
(Less) Questioned Costs								
Allowable Expenses Per Audit (Deficiency)/Excess Over Maximum Allowable Expenses								
STATE MAXIMUM ALLOWABLE EXPENSES \$	\$	\$	\$	\$	\$	\$	\$	\$
(LESS) AMOUNT PAID BY ACS								
DUE TO/(FROM) ACS for over/(under)payment of care days (NOTE _____)								
DUE TO/(FROM) ACS for over/(under)payment of per diem rate (NOTE _____)								
TOTAL DUE TO/(FROM) ACS (NOTE _____)								\$

AGENCY NAME  
PROGRAM NAME\*  
BASIS FOR PER DIEM RATE AS AUDITED  
FISCAL YEAR ENDED \_\_\_\_\_

(3 of 6)  
CONGREGATE CARE  
SCHEDULE OF BASIS  
FOR PER DIEM RATE-AS AUDITED

**SAMPLE**

**TOTAL  
AMOUNT**

Total Agency Reported Expenditures	\$
(Less) Applied Income (as per DSS 2654)	_____
Reported Allowable Expenditures	
(Less) Questioned Costs	_____
<b>TOTAL EXPENDITURES AS AUDITED</b>	<b>\$</b>

**DAYS OF CARE**

ACS Days of Care	
Other Days of Care	_____
<b>TOTAL DAYS OF CARE</b>	_____

**PER DIEM RATE**

Operating Per Diem Rate	\$
Maximum Per Diem Rate: July 1, 20__ to June 30, 20__	\$
** Final Per Diem Rate: July 1, 20__ to June 30, 20__	\$

**CALCULATION OF AMOUNT DUE TO/(FROM) ACS**

July 1, 20_____ to June 30, 20_____	
Maximum Per Diem Rate	\$
Final Per Diem Rate	_____
Difference in Per Diem Rate	
Actual ACS Days of Care	_____
<b>AMOUNT DUE TO/ (FROM) ACS</b>	<b>\$</b>

\*\* Lower of Maximum Per Diem Rate or Operating Per Diem Rate

\* **THE ABOVE SCHEDULE CAN BE USED FOR:**  
**INSTITUTION**  
**GROUP HOME**  
**AGENCY OPERATED BOARDING HOME (AOBH)**  
**GROUP RESIDENCE**

**SAMPLE**

	<u>TOTAL AMOUNT</u>	<u>ADMINISTRATIVE EXPENDITURES</u>	<u>PASS-THROUGH</u>
Total Agency Reported Expenditures	\$	\$	\$
(Less) Applied Income (as per DSS 2654)	_____	_____	_____
Reported Allowable Expenditures			
(Less) Questioned Costs	_____	_____	_____
TOTAL EXPENDITURES AS AUDITED	\$	\$	\$
 <u>DAYS OF CARE</u>			
ACS Days of Care July 1, 20__ to September 30, 20__			
ACS Days of Care October 1, 20__ to March 31, 20__			
ACS Days of Care April 1, 20__ to June 30, 20__			
Other Days of Care	_____	_____	_____
TOTAL DAYS OF CARE	_____	_____	_____
 <u>PER DIEM RATE</u>			
Operating Per Diem Rate	_____	_____	_____
Maximum Per Diem Rate: July 1, 20__ to September 30, 20__	_____	_____	_____
** Final Per Diem Rate: July 1, 20__ to September 30, 20__	_____	_____	_____
Maximum Per Diem Rate: October 1, 20__ to March 31, 20__	_____	_____	_____
** Final Per Diem Rate: October 1, 20__ to March 31, 20__	_____	_____	_____
Maximum Per Diem Rate: April 1, 20__ to June 30, 20__	_____	_____	_____
** Final Per Diem Rate: April 1, 20__ to June 30, 20__	_____	_____	_____
 <u>CALCULATION OF AMOUNT DUE TO/(FROM) ACS</u>			
July 1, 20__ to September 30, 20__			
Maximum Per Diem Rate	\$		
Final Per Diem Rate	\$		
Difference in Per Diem Rate			
Actual ACS Days of Care	_____		
AMOUNT DUE TO/ (FROM) ACS	\$		
October 1, 20__ to March 31, 20__			
Maximum Per Diem Rate	\$		
Final Per Diem Rate	\$		
Difference in Per Diem Rate			
Actual ACS Days of Care	_____		
AMOUNT DUE TO/ (FROM) ACS	\$		
April 1, 20__ to June 30, 20__			
Maximum Per Diem Rate	\$		
Final Per Diem Rate	\$		
Difference in Per Diem Rate			
Actual ACS Days of Care	_____		
AMOUNT DUE TO/ (FROM) ACS	\$		

\*\* Lower of Maximum Administrative Rate or Operating Administrative Rate plus Operating Pass-Through Rate

\* THE ABOVE SCHEDULE CAN BE USED FOR:  
**FOSTER BOARDING HOME**  
**EMERGENCY FOSTER BOARDING HOME**  
**TFBH**  
**MEDICAL/AIDS/SPECIAL NEEDS**

FOSTER CARE AGENCY
Schedule of Miscellaneous Expenses
From July 1, 20XX - June 30, 20XX

Objective: To ensure the miscellaneous expenses are reported only in SOP line 44A & 45. Auditor should request updated expenditures category.

Table with columns: EXPENDITURES (As Applicable), REIMBURSEMENT. Rows include: Anger Management, Bed Bugs, Bus Matron, Camp Fees Day Camp, Camp Fees Residential, Car Seats, Child Care, Child Care Outside NY, Circle of Support, College Room and Board, Counseling, Court Orders, Cribs and Furnitures, Domestic Violence, Drug Testing, Drug Treatment Program, Emergency Clothing, Exception to Policy, Fair hearing Adjustments, Finders Fee, Funeral Expense, Gifts, Graduation, High Chairs, Hillside Center, Hobby/Recreation, Immigration Services, Initial Clothing, Kids Peace, Laid Law Transportation, Loss of Personal Property, Medical/Prescription, Non-Medical, One to One Supervision, Other, School Expense, Sex Offender Therapy, Sign Language Interpreter, Special Admin Rates, Translation, Transportation, Tutoring, TOTAL, LESS: REPORTED IN SSOP (Line 44A & 45), VARIANCE.

**FOSTER CARE AGENCY**  
**SCHEDULE OF CAREDAYS REPORTED**  
 From July 1, 20XX - June 30, 20XX

**Objective:** To reconcile the reported caredays in SSPS to SSOP. Auditor should request updated SSPS caredays from ACS.

<b>PROGRAM L O D</b> (As Applicable)	<b>FISCAL YEAR CAREDAYS</b>		
	<b>PER SSPS</b>	<b>PER SSOP</b>	<b>VARIANCE</b>
FBH	XXX	XXX	XXX
TFBH	XXX	XXX	XXX
INSTITUTION	XXX	XXX	XXX
HTP	XXX	XXX	XXX
GROUP HOME	XXX	XXX	XXX
AOBH	XXX	XXX	XXX
SILP	XXX	XXX	XXX
<b>TOTAL</b>	<b>XXX</b>	<b>XXX</b>	<b>XXX</b>

Remarks on Variance: