

Guidance

Executive Order #38 and **Related Regulations**



November
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INTRODUCTION AND OVERVIEW

This document is intended to assist individuals/entities subject to the regulations promulgated pursuant to Governor Cuomo's Executive Order No. 38 (EO 38) by presenting the requirements of the EO 38 related regulations (the regulations) in an easily understandable, useable format, including a suggested method to make determinations. Each Section summarized in this Introduction and Overview is provided greater detail and discussion in the Sections A – F that follow, and the Appendices. Many terms contained within this document are defined by the regulations or are referenced as part of other relevant programs (e.g., IRS Form 990 reporting; a link to the definition contained within Appendix A is provided the first time a defined term is used. Where such definitions are provided, the definitions from the regulation control; where such regulatory definitions do not exist, definitions used for purposes of IRS compliance should be used, where applicable. This document will be updated and amended as necessary.

The EO 38 regulations place limits on Administrative Expenses and Executive Compensation for certain individuals/entities that receive State Funds or State-Authorized Payments (SF/SAP). The regulations were promulgated by the following State agencies, with an effective date of July 1, 2013:

- Agriculture & Markets
- Division of Criminal Justice Services
- Department of Corrections and Community Supervision
- Department of Health
- Department of State
- Homes and Community Renewal
- Office for the Aging
- Office of Alcoholism and Substance Abuse Services
- Office of Children and Family Services
- Office of Mental Health
- Office for People with Developmental Disabilities
- Office of Temporary and Disability Assistance
- Office of Victim Services

To determine compliance with the limitations contained in the regulations, several determinations and calculations are necessary. Below, guidance is provided regarding the applicability of the regulations to an individual/entity, determining whether a Covered Provider is in compliance with the regulatory limits on Administrative Expenses and Executive Compensation for the Covered Reporting Period, the waiver process, and an explanation of the corrective action and penalties process. Throughout this document, the guidance contains links

to the specific areas of guidance, as well as links to several worksheets, provided to assist individuals/entities with determinations and calculations.

I. Determining Covered Provider Status

Individuals/entities that receive SF/SAP to provide Program Services may be subject to the limitations on administrative expenses and executive compensation outlined in the regulations if they qualify as a Covered Provider. To determine whether an individual/entity is (or is projected to qualify as) a Covered Provider for a Covered Reporting Period (CRP), and therefore likely to be subject to the regulatory limitations, there are several steps that an individual/entity must complete (see also Covered Provider Determination Worksheet):

1. **Governmental Exemption** – Determine whether the exemption for governmental entities applies. If this exemption applies, the provider does not qualify as a Covered Provider and the regulations do not apply.
2. **Reporting Period** – Determine the individual's/entity's Covered Reporting Period (this must be determined before the following questions can be answered). This period will vary among individuals/entities depending on the annual Cost Reports they file with State agencies for SF/SAP received, their fiscal year or the calendar year.
3. **Program Services** – Determine whether Program Services were provided during the Covered Reporting Period. If no Program Services were provided during the Covered Reporting Period, the individual/entity does not qualify as a Covered Provider for the Covered Reporting Period – but it may qualify in the future if its circumstances change.
4. **Other Exemptions from Covered Provider Status** – Determine whether any of the additional exemptions apply. For example, there is an exemption for those individuals/entities that provide primarily products, an exemption for individuals/entities that receive certain specific child care subsidies, and some State agency-specific exemptions for individuals/entities receiving SF/SAP solely through certain specific agencies (i.e. DOH and OCFS). If any of these exemptions apply, the individual/entity does not qualify as a Covered Provider during the Covered Reporting Period; but, may qualify as a Covered Provider in the future if circumstances change.

5. **Determining State Funds/State-Authorized Payments (SF/SAP) Received** – Determine the amount of SF/SAP the individual/entity received during the CRP and the one-year period immediately prior (To assist individuals/entities in calculating SF/SAP, a State Funds/State-Authorized Payments Worksheet has been developed). To make this calculation, an individual/entity must:
 - a. Determine the applicable timeframe for the calculation. Note: Calculations for both the CRP and the one-year period immediately prior are necessary to determine whether an individual/entity qualifies as a Covered Provider for the CRP.
 - b. Determine the best method for capturing and compiling the total amount of SF/SAP received during the applicable periods. Some providers may calculate SF/SAP by aggregating the amount of funding received from each State agency as a whole; others may prefer to aggregate the amount of funding received from each government program. Either method is acceptable. To assist individuals/entities in making this determination, a list of government programs that includes all SF/SAP has been developed, along with guidance on how to use the list of government programs, has been developed.
 - c. Determine what amounts, if any, of public funds received are subject to exclusion from the calculation of SF/SAP.

6. **Calculating SF/SAP Received During the Applicable Periods** – Determine whether the SF/SAP received in the CRP and the one-year period immediately prior is sufficient to meet the average annual amount of \$500,000 requirement that, in part, defines a Covered Provider. If the individual/entity does not meet the \$500,000 requirement in the Covered Reporting Period and the one-year period immediately prior, it is not a Covered Provider for the Covered Reporting Period.

7. **Calculating the Percentage of In-State Revenue Derived from SF/SAP** – Determine the total in-state revenues the individual/entity received during the Covered Reporting Period and the one-year period immediately prior. Calculate the SF/SAP as a percentage of total in-state revenues received in the CRP and the one-year period immediately prior to determine if it meets the 30% of total annual in-state revenue requirement. If the individual/entity does not meet the 30% of total annual in-state revenue requirement in the CRP and the one-year period immediately prior, it is not a Covered Provider for the CRP.

II. Determining Compliance with Administrative Expenses Limitations

If an individual/entity has determined that it is a Covered Provider (or is projected to qualify as a Covered Provider), it can then determine whether it is in compliance with the Administrative Expenses limitations set forth in the regulations. Unless a waiver is granted, the regulations set the following limitations on Administrative Expenses that apply to Covered Providers:

Administrative Expenses must not exceed 25% for a Covered Reporting Period beginning between July 1, 2013 and June 30, 2014; Administrative Expenses must not exceed 20% for a Covered Reporting Period beginning between July 1, 2014 and June 30, 2015; and, Administrative Expenses must not exceed 15% for a Covered Reporting Period beginning July 1, 2015 or thereafter.

To determine compliance with the Administrative Expenses limitations, a Covered Provider must determine which of its expenses are considered Covered Operating Expenses. Of those expenses considered Covered Operating Expenses, a Covered Provider must then determine which are considered Program Services Expenses and which are considered Administrative Expenses, calculating the amount of funding attributable to each category. To assist Covered Providers in determining which of its Covered Operating Expenses are Administrative Expenses and Program Services Expenses, a Program Services Expenses and Administrative Services Expenses Worksheet has been developed.

To determine which Covered Operating Expenses are Program Services Expenses and Administrative Expenses, a Covered Provider must:

1. Refer to the regulations for definitions and criteria
2. Categorize and calculate Program Services Expenses in three categories:
 - a. Salaries and benefits;
 - b. Specific other expenses; and
 - c. Housing
3. Categorize and calculate Administrative Expenses in two categories:
 - a. Salaries and benefits; and
 - b. Specific other expenses
4. Categorize and calculate those expenses that are other-than-Covered Operating Expenses, which shall not be counted toward either Program Services Expenses or Administrative Expenses.

Once these calculations have been made, a Covered Provider can then determine whether the percentage of Covered Operating Expenses related to Administrative Expenses exceeds the limitations.

For organizations that receive rate/fee-based SF/SAP and are therefore unable to calculate specific costs paid with such SF/SAP, these providers may instead perform such calculations based upon their entire revenue.

III. Determining Compliance with Executive Compensation Limitations

If an individual/entity has determined that it is a Covered Provider (or is projected to qualify as a Covered Provider), it can then determine whether it is in compliance with the Executive Compensation limitations set forth in the regulations. To do so, a Covered Provider must first determine which of its executives are likely to be considered Covered Executives. This requires the Covered Provider to determine:

1. Which individuals are compensated directors, trustees, managing partners, officers and key employees whose overall compensation exceeded \$199,000 during the Covered Reporting Period;
2. Which individuals are clinical and program personnel fulfilling administrative functions that are directly attributable to and comprise Program Services, and are therefore excluded; and
3. Which individuals employed by related organizations must be considered Covered Executives of the Covered Provider (imputed Covered Executives).

Once the Covered Provider has determined which individuals are likely to be considered Covered Executives, then the Covered Provider can calculate the Executive Compensation provided (An Executive Compensation Calculation Worksheet has been developed to assist Covered Provider with these calculations). To perform this calculation for each potential Covered Executive, a provider must:

1. Identify the name and title of the potential Covered Executive;
2. Identify the Covered Reporting Period for which the Executive Compensation is being calculated;
3. Determine the executive's gross compensation; and

4. Determine the amount of compensation paid to the executive to render Program Services that is to be excluded from the Executive Compensation calculation
5. Determine which compensation is provided pursuant to a contract entered into between a Covered Provider and a Covered Executive prior to July 1, 2012 that is not subject to the limitations until the end of the term of the contract or April 1, 2015 – whichever comes first.

After the Covered Executives have been determined and an Executive Compensation calculation has been performed for each Covered Executive, a Covered Provider has the opportunity to demonstrate that, although the Covered Executive's compensation is above the \$199,000 limit, it falls below the 75th percentile in a chosen comparable compensation survey and has been reviewed and approved by the covered provider's Board of Directors or equivalent governing body as outlined in the EO 38 regulations. If the Covered Executive's compensation is above the 75th percentile in a comparable compensation survey and/or has not been approved by the board of director or governing body, the Covered Provider must then either take action to bring the Executive Compensation paid to a Covered Executive into compliance with the regulations, or seek a waiver. For the timing of waiver applications, see Section E, following on this page.

For organizations that receive rate/fee-based SF/SAP and are therefore unable to calculate specific costs paid with such SF/SAP, these providers may instead perform such calculations based upon their entire revenue.

IV. EO #38 Disclosure Form Submission

Covered Providers must submit an EO #38 Disclosure Form no later than 180 days after the close of their Covered Reporting Period. The EO #38 Disclosure Form will require Covered Providers to attest to the veracity of the information reported on the form. Disclosures demonstrating the Program Services Expenses Administrative Expenses incurred using SF/SAP will be required, as well as disclosures showing the Executive Compensation paid to the Covered Executives of the organization. If a Covered Provider exceeds (or projects that it will exceed) the Administrative Expenses or Executive Compensation limitations, it may submit a timely waiver application no later than submission date of its EO #38 Disclosure Form. If a Covered Provider exceeds the limitations and a waiver is not granted, then it may be required to submit a plan of corrective action and, ultimately, may be subject to penalties.

V. Waiver Applications

If a Covered Provider exceeds (or projects that it will exceed) the Administrative Expenses and/or Executive Compensation limitations within a Covered Reporting Period, it may apply for a waiver. Waiver applications must be submitted no later than concurrent with the timely submission of the Covered Provider's EO #38 Disclosure Form (due no later than 180 days after the close of the provider's Covered Reporting Period). Providers that anticipate qualifying as a Covered Provider at the end of their Covered Reporting Period and anticipate exceeding the Administrative Expenses and/or Executive Compensation limitations, but for whom the Covered Reporting Period has not ended, may apply for a waiver at any time in advance of the submission of the EO #38 Disclosure Form.

An Administrative Expenses waiver application, if granted, is valid only for the specific time period and to the amount stated therein. Likewise, an Executive Compensation waiver application, if granted, is valid only for the Covered Executives, the amounts for each Covered Executive, and for the specific time period stated therein.

While waiver applications may be submitted at any time prior to the timely submission of the EO #38 Disclosure Form, waiver applications submitted before the close of the applicative CRP based upon projected financial data rather than actual financial data will be subject to a final reconciliation and determination based on actual financial data. Waiver applications based on projections may require additional information (such as actual data, or historical trend data) to be considered and processed. In addition, waiver applications based on projected data will, if approved, be subject to a conditional approval limited to the extent that the projected data matches the actual data at the end of the applicable Covered Reporting Period. Therefore, it is important that an individual/entity make a good faith effort to accurately project data as outlined in the Covered Provider Determination section, the Administrative Expenses calculation section and Executive Compensation determination and calculation section.

Covered Providers seeking a waiver from either the Executive Compensation or Administrative Expenses limitations must first create a user account. After that account is created, the Covered Provider may then apply for a waiver from the Administrative Expenses limitations or for a Covered Executive.

Administrative Expenses Waiver Application Requirements:

1. Covered Operating Expenses
2. Administrative Expenses and Percentage
3. Program Services Expenses and Percentage
4. Rationale for Exceeding the Limits
5. A description of the unavailability of such expenses
6. Provide evidence of the impact not paying such expenses would have on the Covered Provider
7. A description of the control processes utilized
8. A description of any alternative funding sought

Executive Compensation Waiver Application Requirements:

1. Covered Executive's Name (if applicable)
2. Position/Title
3. Executive Compensation provided to the Covered Executive
4. Executive Compensation derived from SF/SAP
5. A description of compensation provided to comparable executives
6. A description of how essential the executive is to the Covered Provider
7. A description of the compensation review process
8. Disclosure of whether the compensation exceeds the 75th percentile of comparable executives, and if so by how much and a description of the rationale for providing such compensation
9. A description of the qualifications of the executive
10. A description of any recruiting alternatives pursued

VI. Plans of Corrective Action and Penalties

If a Covered Provider is found to be out of compliance with the requirements in the regulations, either through the review of an *EO #38 Disclosure Form* or through failure to submit an *EO #38 Disclosure Form*, State agencies will commence corrective action with the Covered Provider. This is considered the Plan of Corrective Action/Penalties period.

If non-compliance is determined, a *Notice of Determination of Non-Compliance* will be sent to the Covered Provider, outlining the basis for the determination. The Covered Provider then has 30 calendar days in which to submit additional or clarifying information. If additional or clarifying information is submitted, the State agencies will examine that information to determine whether to uphold the finding of non-compliance or find the Covered Provider in compliance. If additional or clarifying information is not submitted, the *Notice of Determination of Non-Compliance* becomes final and a *Notice to Cure* will be sent to the Covered Provider. The *Notice to Cure* will give the Covered Provider no less than six months to correct any violations, and require the submission of a *Corrective Action Plan (CAP)* within 30 calendar days of receipt of the *Notice to Cure*.

If a Covered Provider is required to submit a *CAP*, the *CAP* will outline specific actions to be taken and identify a timeline for achieving milestones and completing the *CAP*. Once received, the State agencies have thirty (30) calendar days in which to approve, request clarification, or request alterations to the *CAP*. Once approved by the State agencies, the Covered Provider has 6 months in which to implement the *CAP*, unless an alternative time period is approved by the State agencies. At the conclusion of the implementation period, the State agencies may

request information to determine if the *CAP* was properly implemented. If the *CAP* was properly implemented, the matter is then considered closed; if the *CAP* was not properly implemented, the State agencies will issue a *Notice of Failure to Cure*.

The *Notice of Failure to Cure* will outline the factual basis for the determination and any additional actions to be taken against the Covered Provider, including modifications to the *CAP* or the issuance of a *Notice of Sanctions Due to Non-Compliance* and the Covered Provider's opportunity to appeal. *Notice of Sanctions Due to Non-Compliance* may include, but is not limited to, redirection of SF/SAP from the Covered Provider, changes to the Covered Provider's license/operating certificate, changes to any contracts or other agreements, and referral for legal action.

A Covered Provider may file a written *Request for Appeal* to a *Notice of Sanctions Due to Non-Compliance* within thirty (30) calendar days of receipt, containing an explanation of the basis for the challenge and all documentation to support the Covered Provider's position. If such an appeal is submitted, the State agencies will review and make a written determination, providing a final *Notice of Decision on Appeal* to the Covered Provider. If the Covered Provider is found to be non-compliant, the sanctions outlined in the *Notice of Sanctions Due to Non-Compliance* will be imposed.

Section A.

COVERED PROVIDER STATUS DETERMINATION

The regulations apply only to those individuals/entities that qualify as Covered Providers. Use of the Covered Provider Determination Section is recommended, but not required, to determine an individual's/entity's status. However, the provider must be able to demonstrate how it determined its Covered Provider status in the event of an audit. Therefore, the provider should keep a copy of the determination summary or maintain a copy of the calculations and any other documentation that were used to determine whether they are or are not covered.

When using the Covered Provider Determination Section (CPDS):

1. Review all guidance, regulations, definitions, and terminology before completing the form.
2. The method of accounting used by the individual/entity in producing annual financial reports should be used in all EO38 related calculations.
3. The CPDS does not necessarily contain all scenarios or factors that individuals/entities must consider when determining Covered Provider status. Completion of the worksheet should not be exclusively relied upon for determining Covered Provider status, as it relies upon other calculations and worksheets for its completion.
4. Supporting documentation, including any of the recommended EO38 worksheets utilized, should be kept on file by the individual/entity, and provided to the State, upon request.
5. Keep a record of the source documents used in preparation of any worksheets and calculations.

To complete the CPDS, an individual/entity will have to access its original source information, answer specific questions, and, at certain points in the section, will be directed to recommended sub-processes.

The topic areas included in the CPDS described within this document are:

- A. Initial Exemptions
- B. Reporting Period
- C. Program Services
- D. Additional Exemptions
- E. State Funds/State Authorized Payments (SF/SAP) Received
- F. Total In-State Revenues
- G. State Funds/State Authorized Payments (SF/SAP) as a Percentage of In-State Revenues

The use of this section and its associated sub-processes yields the following results:

- Determination of the individual's/entity's reporting periods
- Calculation of the SF/SAP for use in administering the \$500,000 test
- Calculation of the percentage of SF/SAP as in-state revenues for use in administering the 30% test
- Information to determine the individual's/entity's status as a Covered Provider for the CRP

Procedure

The following procedure for determination of Covered Provider status is suggested.

A. Initial Exemption^a

If an individual/entity meets any of the criteria delineated in 1 through 4 below, that individual/entity is not considered a Covered Provider and accordingly, is exempt from the provisions of the regulations, including the need to submit an EO 38 Disclosure Form and apply for a waiver from the limitations contained within the regulations.

- 1) The individual/entity is a state, county or local government unit in NYS
- 2) The individual/entity is one of the tribal governments for one of the nine nations recognized by NYS. Those nine nations are: Seneca, St. Regis Mohawk, Cayuga, Tonawanda, Tuscarora, Onondaga, Oneida, Unkechaug and Shinnecock.
- 3) The individual/entity is a subdivision or subsidiary of a state, county or local government in NYS
- 4) The individual/entity is a subdivision or subsidiary of one of the tribal governments for one of the nine nations recognized by NYS

IF AN INDIVIDUAL/ENTITY MEETS ANY OF THE CRITERIA OUTLINED ABOVE, THAT INDIVIDUAL/ENTITY IS **NOT CONSIDERED A COVERED PROVIDER** AND ACCORDINGLY, IS EXEMPT FROM THE PROVISIONS OF THE REGULATIONS.

IF AN INDIVIDUAL/ENTITY DOES NOT MEET ANY OF THE CRITERIA OUTLINED ABOVE, THAT INDIVIDUAL/ENTITY MUST PROCEED TO DETERMINE THEIR COVERED PROVIDER STATUS.

B. Reporting Periods

Under the regulations, the Reporting Period is that annual period of time to be used by providers for EO 38 compliance and reporting. The Covered Reporting Period (CRP) is the provider's most recently completed annual Reporting Period commencing on or after July 1, 2013. The CRP and the one-year period immediately preceding the CRP are used to determine Covered Provider status, as well as the timing of various parts of the waiver and reporting process. However, the individual/entity providing Program Services must first define its Reporting Period and determine which Reporting Period is the first CRP. This section is intended to offer guidance in this determination.

The regulations provide for some flexibility in determining the individual's/entity's CRP. In instances where the individual/entity is required to submit an annual Cost Report, then the Reporting Period must run concurrent with the period covered by the Cost Report. Lacking a Cost Report, the individual/entity may use either of two options to determine the CRP: 1) the calendar year; or, 2) the individual's/entity's fiscal year.

NOTE: Only those Cost Reports recognized for EO 38 purposes may be used by an individual/entity to determine the CRP. Those Cost Reports are listed in Appendix C.

COST REPORT

For providers required by the State to file an annual Cost Report, a period of one year coinciding with the same time frame required by the State in the Cost Report(s) shall be used for the individual's/entity's reporting period. For individuals/entities that file a Cost Report with more than one of the State agencies that have published the regulations, the individual/entity may choose the Cost Report to be used to determine its reporting period.

If there is no cost report required of the provider, the reporting period is at the option of the provider:

CALENDAR YEAR

a. A period of one Calendar Year beginning January 1st and ending December 31st or,

FISCAL YEAR

b. A period of one Fiscal Year (FY) coinciding with the same time frame as the fiscal year used by the provider.

Examples

The following examples illustrate: 1. the determination of an individual's/entity's Reporting Period; and 2. the determination of that individual's/entity's CRP and the one-year period immediately prior to the CRP.

1. No cost report required:

On July 1, 2013, Companies Red and Purple are engaged in contracting activities with New York State and are not required by any NYS Agency to file annual cost reports. Accordingly, each company may determine its own CRP.

Company Red chooses as its Reporting Period the calendar year. Thus, *the first full CRP for Company Red following the 7/1/13 effective date of the limitations contained within the regulations would be 1/1/2014 through 12/31/2014. The period immediately preceding the CRP would be 1/1/2013 through 12/31/13.*

Company Purple chooses to use as its Reporting Period the company's fiscal year; annually this is a period beginning 6/1 and ending 5/31. Thus, *the first full CRP for Company Purple following the 7/1/13 effective date of the limitations contained within the regulations would be 6/1/2014 through 5/31/2015. The period immediately preceding the CRP would be 6/1/2013 through 5/31/14.*

2. Cost Report Required:

On July 1, 2013, Companies Green and Pink are involved in contracting activities with multiple NYS Agencies and are required to file an annual Cost Report by one or more of those agencies.

Company Green has been required, since 2008, by one NYS Agency to file an annual Cost Report covering its fiscal activities using a reporting cycle beginning each year on October 1st. For purposes of the regulations, this annual cycle would be used as its CRP. Accordingly, *the first full CRP for Company Green following the effective date of the limitations contained within the regulations would be 10/1/2013 through 9/30/2014. The period immediately preceding the CRP would be 10/1/2012 through 9/30/2013.*

Company Pink is required by three NYS Agencies to file three different annual Cost Reports and the timing of the reporting cycles for each of these Cost Reports varies by requesting agency:

- Agency P: 4/1 through 3/31;
- Agency Q: 9/1 through 8/31;
- Agency Z: 10/1 through 9/30.

Company Pink determines that the Cost Report associated with the largest amount of funding is the Cost Report filed with Agency Z and the Cost Report period is from 10/1 through 9/30. Thus, *the first full CRP for Company Pink following the effective date of the limitations contained within the regulations would be 10/1/2013 through 9/30/2014. The period immediately preceding the CRP would be 10/1/2012 through 9/30/13.*

C. Program Services

This step requires an entity to examine its service profile to determine if Program Services defined by the regulations are provided. If an individual/entity does not provide Program Services as defined by the regulations in the CRP, then the regulations do not apply.

Therefore, the entity/individual does not need to submit an EO 38 Disclosure Form or apply for a waiver from the limitations contained within the regulations.

IF AN INDIVIDUAL/ENTITY DOES NOT PROVIDE PROGRAM SERVICES, THAT INDIVIDUAL/ENTITY IS **NOT CONSIDERED A COVERED PROVIDER** AND ACCORDINGLY, IS EXEMPT FROM THE PROVISIONS OF THE REGULATIONS.

IF AN INDIVIDUAL/ENTITY PROVIDES PROGRAM SERVICES, THAT INDIVIDUAL/ENTITY MUST PROCEED TO THE NEXT PART TO DETERMINE ITS COVERED PROVIDER STATUS.

GO TO STATE FUNDS/STATE-AUTHORIZED PAYMENTS (SF/SAP)

CALCULATION WORKSHEET

To complete the remainder of the Covered Provider determination, the SF/SAP must first be calculated for the CRP and the one-year period immediately prior to the CRP. The guidance associated with the SF/SAP Calculation Worksheet contained within Section B can assist with these calculations. Once these figures are calculated, they can be used to complete the remainder of the Covered Provider Determination Worksheet.

D. Additional Exemptions^a

To determine the answer to question 4.a., consider:

Is the individual/entity an individual professional, partnership, S Corporation or other entity for which at least 75 percent of its Program Services paid for by SF/SAP were provided by the individual professional(s), by the partner(s) or by the owner(s) of the corporation or entity, themselves, rather than by employees or contractors?

To determine the answer to question 4.b., consider:

Does the individual/entity provide primarily or exclusively products, rather than services, in exchange for SF/SAP? Examples of such entities that are typically purveyors of products, rather than services, are pharmacies and medical equipment suppliers. For the purpose of applying this exemption, the individual's/entity's percentage of revenues derived from products rather than from services must be greater than 50 percent. An individual/entity seeking to invoke this exception will need to calculate the percentage of revenues for services and for products, as part of its total revenues. This calculation should be based on the individual's/entity's method of accounting and kept on file, as part of its supporting documentation.

To determine the answer to question 4.c., consider:

Does the individual/entity provide only child care services and only receive child care subsidies pursuant to Title 5-C or Section 410 of the Social Services Law?
Individuals/entities that also receive SF/SAP that are not child care subsidies pursuant to Title 5-C or Section 410 of the Social Services Law do not qualify for this exemption and must continue with the Covered Provider determination process.

To determine the answer to question 4.d., consider:

Office of Children and Family Services (OCFS) exemption: Does the individual/entity receive public funding exclusively from OCFS and a social services district for maintenance costs for children cared for through a residential placement made by a committee on special education under the Education Law?

Department of Health (DOH) exemption: Does the individual/entity receive SF/SAP exclusively through/from the Department of Health and is NOT on the following list of providers:

- hospitals and nursing homes, both as defined in public health law article 28;
- home care services agencies,, licensed home care agencies, certified home health agencies, residential health care facilities, long term home health care programs, AIDS home care programs, all as defined in public health law article 36;
- hospice residences as defined in public health law article 40;
- assisted living residences and enhanced assisted living residences as defined in public health law article 46-B;
- ambulance services and advanced life support first response services as defined in public health law article 30;
- adult day health care as defined in 10 NYCRR part 425;
- health maintenance organizations, as defined in Article 44 of the public health law and other entities approved to operate by the department under article 44 of the public health law;
- intermediate care facilities as defined in article one of the social services law;
- entities conducting evaluations or providing services in the early intervention program established in Title II-A of Article 25 of the public health law;
- assisted living programs as defined in section 461-l of the social services law; or
- an independent practice association or a management contractor, as such terms are defined in 10 NYCRR part 98, that is a related organization to a covered provider.

Corporate Families

An exemption listed in the regulation, but that is not on the CPDS involves entities within the same corporate family as a covered provider, including parent or subsidiary corporations or entities, **unless** such corporation or entity would otherwise have qualified as a Covered Provider. The CPDS has been designed to be applied to all entities, including those within the same corporate family as a Covered Provider, to allow them to determine their status as a Covered Provider, independent of a parent or subsidiary corporation or entity. An individual/entity does not become a Covered Provider merely because it is in the same corporate family as a Covered Provider. If an individual/entity is in the same corporate family as a Covered Provider, to determine its own Covered Provider status, that individual/entity should consider only funding that it received when completing the CPDS.

IF AN ENTITY/INDIVIDUAL QUALIFIES FOR ANY OF THE EXEMPTIONS CONTAINED WITHIN QUESTIONS 4a, 4b, 4c, OR 4d, THAT ENTITY/INDIVIDUAL **IS NOT A COVERED PROVIDER** DURING THE CRP, AND ACCORDINGLY, IS EXEMPT FROM THE PROVISIONS OF THE REGULATIONS.

IF AN ENTITY/INDIVIDUAL DOES NOT QUALIFY FOR ANY OF THE EXEMPTIONS CONTAINED WITHIN QUESTIONS 4A, 4B, 4C OR 4D, THAT ENTITY/INDIVIDUAL MUST PROCEED TO THE NEXT PART TO DETERMINE THEIR COVERED PROVIDER STATUS.

Covered Provider Tests

This section of the guidelines is intended to assist providers in determining if they meet the \$500,000 two-year average and 30% in-state revenue thresholds required to qualify as a Covered Provider. In order to be considered a Covered Provider an individual/entity providing Program Services must have received SF/SAP during the CRP and the one-year period immediately preceding the CRP. By this point, individuals/entities must have calculated their SF/SAP for the CRP and the one-year period immediately preceding.

E. State Funds/State-Authorized Payments (SF/SAP) Received

Enter the amount of SF/SAP calculated to have been received in the CRP and the one-year period immediately prior.

State Funds/State Authorized Payments (SF/SAP) Received

One of the criteria used to determine Covered Provider status is the total dollar value of SF/SAP received by an individual/entity providing Program Services during the CRP and the one-year period immediately prior. Once SF/SAP calculations are performed, the individual/entity must determine within the CRP and the one-year period immediately prior – when taken together – whether such funding averages at least \$500,000 for each period.

The following questions on the CPDS are designed to assist in applying the \$500,000 test in the regulations.

Answer CPDS question 5:

If *no* SF/SAP were received in the CRP, the individual/entity need not continue in completion of the form. The individual/entity is **not a Covered Provider**.

If SF/SAP were received in the CRP, the individual/entity must answer CRWD question 6:

Answer CPDS question 6:

If *no* SF/SAP were received in the one-year period immediately preceding the CRP, the individual/entity need not continue in completion of the form. The individual/entity is **not a Covered Provider**.

If SF/SAP were received in the one-year period immediately preceding the CRP, the CPDS will calculate the average of the funding received in these two time periods.

Calculation Methodology: The CPDS collects and adds the amounts of SF/SAP received in the CRP and the one-year period immediately preceding the CRP and divides the total by two. That total is displayed on line 6a of the CPDS.

\$500,000 Two-year Average Funding Test: An individual/entity for which the average amount of SF/SAP received in the CRP and the one-year period immediately preceding exceeds \$500,000 must continue in the Covered Provider determination by performing the 30% test. Conversely, when this average is less than \$500,000 the individual/entity is not considered a Covered Provider and accordingly, is exempt from the provisions of the regulations.

The \$500,000 Two year Average Funding Test is performed by answering this question:

Is the resulting average amount greater than \$500,000?

If the resulting average amount is not greater than \$500,000, the individual/entity is **not a Covered Provider**.

If the resulting average amount is greater than \$500,000, the individual/entity must continue with the Covered Provider determination process.

F. Total In-State Revenues

The calculation of the SF/SAP as a percentage of in-state revenues is a two-step process. First, the individual/entity must record the amount of total in-state revenues in the CRP and the one-year period immediately preceding. Second, the SF/SAP amount for both the CRP and the period immediately preceding must be divided by the relative amounts of in-state revenues.

Section F of the CPDS assists individuals/entities in determining their in-state revenues, which revenues received from and in connection with activities conducted within NYS. In-state revenues may include revenues received from outside NYS if those revenues were used in connection with activities within NYS. This calculation must be performed for the CRP and the one-year period immediately preceding.

The CPDS will use the data entered in response to questions 5 and 7, and 6 and 8 to calculate the SF/SAP as a Percentage of In-state Revenues received in the CRP and that received in the one-year period immediately preceding, respectively, and will display the percentage for each period.

G. SF/SAP as Percentage of In-State Revenues

30% of In-State Revenues Received Test: Section G of the CPDS provides the results of the 30% test for both the CRP and the one-year period immediately preceding. This test involves calculating whether at least 30% of an individual's/entity's total in-state revenues were derived from SF/SAP; a calculation that must be performed for both the CRP and the one-year period immediately preceding.

Interpretation of Results – CRP

If the individual/entity did not receive >30% of its in-state revenues from SF/SAP in the CRP, the individual/entity is **not a Covered Provider** and accordingly, is exempt from the provisions of the regulations

If the individual/entity did receive > 30% of in-state revenues from SF/SAP in the CRP, the individual/entity needs to evaluate its status further by evaluating the SF/SAP percentage for the one-year period immediately prior to the CRP.

Interpretation of Results – One-year period immediately prior to CRP

If the individual/entity did not receive >30% of its in-state revenues from SF/SAP in the one-year period immediately preceding the CRP, the individual/entity is **not a Covered Provider** and accordingly, is exempt from the provisions of the regulations

If the individual/entity did receive > 30% of its in-state revenues from SF/SAP in the CRP **and** the one-year period immediately preceding, the individual/entity has met all of the Covered Provider tests and **is considered a Covered Provider.**

REMEMBER

A Covered Provider must have received a two-year average amount of SF/SAP greater than \$500,000 in the CRP and the one-year period immediately prior to the CRP.

In addition to meeting that condition, a Covered Provider must have received greater than 30% of its in-state revenues from SF/SAP for **both** of those periods.

Section B.

STATE FUNDS/STATE-AUTHORIZED PAYMENTS

CALCULATION

As part of the Covered Provider Determination Section (CPDS), an individual/entity must determine the amount of State Funds/State-Authorized Payments (SF/SAP) it received during the CRP and the one-year period immediately prior. To assist individuals/entities in calculating the SF/SAP they received in the CRP and the one-year period immediately prior, a SF/SAP Worksheet has been developed.

Calculation of the amount of SF/SAP requires an individual/entity to:

- a. Determine whether to calculate SF/SAP by the amount of funding received from a State agency as a whole, or by each Government Program from which funds were received. To assist individuals/entities in determining its preferred method of calculation, a list of Government Programs that includes all SF/SAP has been developed along with guidance on how to use the list of government programs (see Appendix B.).
- b. Identify SF/SAP payments received for the CRP and for the one-year period immediately prior and calculate the Gross Total for both time periods, related to each State agency/Government Program, depending upon which method of calculation will be used. *Note: Calculations for both time periods are necessary to complete the CPDS and determine whether an individual/entity qualifies as a Covered Provider for the CRP.*
- c. Calculate the amount of funds received that should be excluded from the calculation of SF/SAP.
- d. Calculate the total amount of SF/SAP received from all appropriate agencies/programs.

Process

In order to complete the SF/SAP Worksheet, the individual/entity will need to decide how its funding is best calculated. It may be easier for an individual/entity to calculate aggregate funding received from individual State agencies (DOCCS, OMH, OTDA, etc.) or by individual

program (Ambulatory Care Training Program [from DOH], Witness Protection Program [from DCJS], Elderly Abuse Prevention [from NYSOFA], etc.). The list of Government Programs has been compiled to assist individuals/entities in recognizing funding that could be considered SF/SAP.

Section B. – State Agencies and Government Programs

There are two ways to calculate SF/SAP received. The method chosen largely depends upon the fiscal information available to the individual/entity. The individual/entity may base the calculation on aggregate funding by each State agency or by summing individual program amounts. The way an individual/entity completes Section B will vary depending on the method chosen by the individual/entity to calculate the amounts.

Examples

**Aggregate
Funding
Amount by
State Agency**

An individual/entity identifies the funding received from each State agency and completes the SF/SAP Worksheet in this way:

	Column A	Column B	Column C
B1.	DOH	OMH	OPWDD
B2.	N/A	N/A	N/A
B3.	\$ 5,000,000	\$ 2,000,000	\$ 450,000

Multiple sheets should be used to report and calculate funding from more than four State agencies.

- **OR** -

**Funding by
Individual
Program**

An individual/entity identifies the funding in support of each Government Program under which it provides Program Services. The entity is able to identify the State agency source of the funds and completes the SF/SAP Worksheet in this way:

DOH Ambulatory Care Training Program (ACTP): \$ 500,000
 DCJS Witness Protection Program (WPP): \$
 500,000
 NYSOFA Elderly Abuse Prevention (EAP): \$
 250,000

	Column A	Column B	Column C
B1.	DOH	DCJS	NYSOFA
B2.	ACTP	WPP	EAP
B3.	\$500,000	\$500,000	\$250,000

Multiple sheets should be used to report and calculate funding from more than four programs

Complete Section C. – State Funds/State Authorized Payments (SF/SAP) Calculation

This section of the Worksheet allows the individual/entity to report funding related to the specific exclusions provided in the regulations by each agency funding amount or Government Program (depending upon the method that was used to complete Section B) and adjust the totals contained in Section B.3., columns A through E, by the total amount of exclusions. In this step, the amount contained in Section B.3. is considered the gross total SF/SAP.

The worksheet then totals the exclusions on line 9, Columns A-E, subtracts that amount from the amounts reported in Section B and reports that amount on line 10, Columns A-E. In this step, line 11 displays the Net Total SF/SAP.

Once completed for the CRP, the individual/entity must then perform the same calculations of SF/SAP received during the one-year period immediately prior to the CRP.

ONCE THE SF/SAP CALCULATION HAS BEEN COMPLETED FOR THE CRP AND THE ONE-YEAR PERIOD IMMEDIATELY PRIOR, RETURN TO COVERED PROVIDER DETERMINATION WORKSHEET STEP D.

Section C.

ADMINISTRATIVE EXPENSES AND PROGRAM SERVICES EXPENSES CALCULATION

This section is for individuals/entities that have determined that they qualify (or are projected to qualify) as a Covered Provider for the CRP. Completion of this section requires previous calculation of the SF/SAP received for the CRP.

NOTE: For organizations that receive rate/fee-based SF/SAP and are therefore unable to calculate specific costs paid with such SF/SAP, these providers may instead perform such calculations based upon their entire revenue.

This section of the Guidance is intended to present a suggested method to assist Covered Providers in calculating the amount and percentage of Administrative Expenses during a CRP in order to determine compliance with the applicable regulatory limits. Guidance concerning the use of worksheets and methodologies for performing calculations is provided as a recommendation only. Regardless of the approach to calculating Administrative Expenses, supporting documentation should be maintained by the Covered Provider to be provided to State agencies upon request.

Administrative Expenses Limits:

- For CRPs commencing between July 1, 2013 and June 30, 2014 – Unless a waiver is granted, no less than 75% Program Service Expenses (no more than 25% Administrative Expenses) as a proportion of Covered Operating Expenses is permitted.
- For CRPs commencing between July 1, 2014 and June 30, 2015 – Unless a waiver is granted, no less than 80% Program Services Expenses (no more than 20% Administrative Expenses) as a proportion of Covered Operating Expenses is permitted.
- For CRPs commencing July 1, 2015 and thereafter – Unless a waiver is granted, no less than 85% Program Services Expenses (no more than 15% Administrative Expenses) as a proportion of Covered Operating Expenses is permitted.

The regulations define Administrative Expenses as those expenses paid with SF/SAP that are incurred in connection with a Covered Provider's management and overhead, but which are not attributable directly to the provision of Program Services. Program Services Expenses are incurred in direct connection with the provision of Program Services. Covered Operating Expenses are the sum of Program Services Expenses and Administrative Expenses for a Covered Provider.

The limitations on Administrative Expenses apply to the percentage of Covered Operating Expenses of a Covered Provider paid for with SF/SAP. Therefore, only SF/SAP should be considered when determining a Covered Provider's amount of Covered Operating Expenses.

Fiscal Framework

**State Funds/State Authorized Payments = Covered Operating Expenses + Other Than
Covered Operating Expenses**

$$\text{SF/SAP} = \text{COE} + \text{O}$$

Under the regulations, a Covered Provider's Covered Operating Expenses (Administrative Expenses and Program Services Expenses), combined with other expenses (those paid with SF/SAP but excluded from both Administrative Expenses and Program Services Expenses) that are not considered Covered Operating Expenses, should equal the total of SF/SAP a Covered Provider received.

It follows, then, that the sum of a Covered Provider's Administrative Expenses and Program Services Expenses should equal a Covered Provider's Covered Operating Expenses:

Covered Operating Expenses = Admin. Expenses + Program Services Expenses

$$\text{COE} = \text{AE} + \text{PSE}$$

Represented as an equation:

**State Funds/State Authorized Payments = Admin. Expenses+ Program
Services Expenses + Other Expenses**

$$\text{SF/SAP} = \text{AE} + \text{PSE} + \text{O}$$

Program Services Expenses and Administrative Expenses Worksheet Content

To complete the Program Services Expenses and Administrative Expenses Worksheet (the worksheet) calculations, a Covered Provider will have to consider its fiscal and programmatic records to determine those expenses that qualify as Covered Operating Expenses (Program Services Expenses and Administrative Expenses) paid during the CRP using SF/SAP. Once the Covered Provider has entered its Program Services Expenses, Administrative Expenses, and expenses that are considered Other Than Covered Operating Expenses (those expenses that are considered neither Program Services Expenses nor Administrative Expenses), the worksheet will allow the Covered Provider to determine:

1. Compliance with the Administrative Expense limitations; and
2. The necessity to secure a waiver of Administrative Expense limits.

When using the worksheet:

1. Review all guidance, regulations, definitions, and terminology before completing the form.
2. The method of accounting used by the Covered Provider in producing annual financial reports should be used in all EO38 related calculations.
3. All supporting documentation, including any of the recommended EO38 worksheets utilized, should be kept on file by the Covered Provider, and provided to the State, upon request.
4. Keep a record of the source documents used in preparation of any worksheets and calculations.

Process

The following is a recommended process for a Covered Provider to calculate Administrative Expenses and determine compliance with the limits on the allowable percentage of Administrative Expenses under the regulations.

The Program Services Expenses and Administrative Expenses Worksheet is designed to capture the amounts of Administrative Expenses and Program Services Expenses, and calculate the percentages of Covered Operating Expenses. These percentages can then be evaluated against the limitations set by the regulations.

AE%	Administrative Expenses % = AE/COE X 100
PSE%	Program Services Expenses % = PSE/COE X 100
AE% + PSE% = 100% COE	
<div style="border: 1px solid black; padding: 2px 10px; display: inline-block;">CHECK</div>	

TIP: When calculating Administrative Expenses and Program Services Expenses, it may be easiest to use the same methodology used for calculating SF/SAP, i.e., using either the “government program-by-government program method,” or by calculating a percentage of overall revenue received from a state agency.

1. Determine SF/SAP received for the Covered Reporting Period

Since Administrative Expenses are a component of SF/SAP, and the remainder of SF/SAP is comprised of Program Services Expenses and Other Than Covered Operating Expenses, a Covered Provider must determine the total amount of SF/SAP received from all sources during the Covered Reporting Period.

2. Calculate the amount of Program Services Expenses, Administrative Expenses, and other expenses

Utilizing the Program Services and Administrative Expenses Worksheet, the SF/SAP received by the individual/entity will be apportioned under each category of expense.

Report amounts under each category: Administrative (A), Program Services (PS), and Other Than Covered Operating Expenses (O) for each type of expense/expense name (e.g., Salaries and Benefits –Direct Care and other). Use the hyperlinks provided for reference to the definitions of the type of expense.

TIP: Familiarize yourself with those expenses that are funded with SF/SAF, which are not Program Services Expenses or Administrative Expenses, but are considered Other Than Covered Operating Expenses, so these expenses are not inadvertently included in the Program Services Expenses and Administrative Expenses categories.

The worksheet is structured to provide for reporting of dollar amounts in specific items of expense, reflected in the column entitled “Expense Name,” which lists items 1-9, 9a-19. Columns labeled (A), (B), and (C) contain data entry cells for reporting dollar amounts

sorted by Program Services, Administrative, and Other (than Covered Operating Expenses), respectively, related to each of the items of expense.

Complete the worksheet for A. Program Services Expenses and B. Administrative Expenses

Dollar amounts for expense Items 1-9 and 9a are to be reported in Column (A) Program Services.

Dollar amounts for expense Items 10 – 13 are to be reported in Column (B) Administrative.

Example

Under the category *Program Services (A)*, a Covered Provider has determined that out of the total amount of SF/SAP received during the Covered Reporting Period, a total of \$500,000 was paid for *Salaries and Benefits-Direct Care and Other* and has entered that amount in expense item 1. The provider determined that these payments met the definition of this category by clicking on hyperlink “b”, which provides this definition of the category:

Expense Name	(A) Program Services	(B) Administrative	(C) Other	Notes a
A. Program Services Expenses				
<i>Salaries and Benefits (Program Services):</i>				
1. Salaries and Benefits-Direct Care and Other	\$ 500,000			b
2. Salaries and Benefits-QA				c
<i>Expenses (Program Services)</i>				
3. Travel (to/from Client residence)				d
4. Direct Care Supplies				
5. Public Outreach/Education/Personnel Training				
6. IT/Computer Services and Systems				
7. QA/QC Expenses				
8. Legal Expenses				
9. Other, including Program Service related housing				e
B. Administrative Expenses				
<i>Salaries and Benefits (Administrative):</i>				
<i>Expenses (Administrative):</i>				
10. Salaries and Benefits (Administrative):				f
11. Legal				g
12. Office Operations				h
13. Other				i

b **Salaries and Benefits-Direct Care and Other (Program Services)** - that amount expended and attributable to that portion of salaries and benefits of staff providing particular program services, including, for example, employees or contractors providing direct care to clients and supervisory personnel and support personnel whose work is attributable to a specific program in whole or in part and contributes directly to the quality or scope of program services provided.

Complete the Worksheet to account for C. Other Expenses.

Complete items of expense 14-19 in column (C) *Other*. This step is necessary to account for all expenses involving SF/SAP received within the CRP.

C. Other than Covered Operating Expenses			
14. Capital Expenses			k
15. Property Rental/Mortgage/Maintenance			l
16. Government taxes/assessments paid/payments in lieu of taxes			m
17. Equipment Rental/Depreciation/Interest			n
18. Non recurring/unanticipated >\$10,000			o
19. Salary and Benefits (Policy Development/Research)			p

Check Calculations – After the amounts have been entered in items of expense 1-9, 9a, and 10-19, the spreadsheet will calculate the category totals and report them on line 20. The Covered Operating Expenses or the sum of Program Services (Column A) and Administrative Services (Column B) is also calculated and reflected on line 21.

Determine D. Category Totals and Percentages

From this information, the worksheet calculates the percentages of Covered Operating Expenses, detailing the percentage of Program Services Expenses and Administrative Expenses.

	Program Services	Administrative	Other	
D. Category Totals	\$ 500,000	\$ -	\$ -	q
20. Covered Operating Expenses (A+B)	\$ 500,000			r
21. % Program Services Expenses	100.0%			
22. % Administrative Expenses	0.0%			

If the total amounts in the Program Services, Administrative and Other columns do not match the known SF/SAP, as identified in the SF/SAP Worksheet, it is possible an error has been made in these forms/calculations. Check the source information, categorization of amounts, and data entry and correct any errors identified.

3. Determine Compliance with the Administrative Expenses Limitation

Administrative Expenses Limits

- For Covered Reporting Periods (CRPs) commencing between July 1, 2013 and June 30, 2014 – Unless a waiver is granted, no less than 75% Program service expenses (no more than 25% Administrative Expenses) as a proportion of covered operating expenses is permitted.
- For CRPs commencing between July 1, 2014 and June 30, 2015 – Unless a waiver is granted, no less than 80% Program Services Expenses (no more than 20% Administrative Expenses) as a proportion of covered operating expenses is permitted.
- For CRPs commencing July 1, 2015 and thereafter – Unless a waiver is granted, no less than 85% Program Services Expenses (no more than 15% Administrative Expenses) as a proportion of covered operating expenses is permitted.

Allowable administrative expenses are based on the percentage of the Covered Operating Expenses that were defined as Administrative Expenses.

Example

The CRP is from July 1, 2013 to June 30, 2104. The Covered Provider's Administrative Expenses as a percentage of Covered Operating Expenses are calculated to be 25.2%. Because 25.2% is greater than the limit of 25% for the first Reporting Period, the Covered Provider has exceeded the limits on allowable Administrative Expenses by 0.2%. The provider must either take action to reduce its Administrative Expenses prior to the close of the applicable reporting period, or seek a waiver from the limit on Administrative Expenses. If no waiver is granted, the Covered Provider will be subject to corrective action and potentially penalties.

Section D.
COVERED EXECUTIVE DETERMINATION,
EXECUTIVE COMPENSATION CALCULATION,
AND COMPLIANCE WITH EXECUTIVE
COMPENSATION LIMITATIONS

This section is for individuals/entities that have determined that they qualify (or are projected to qualify) as a Covered Provider for the CRP.

NOTE: For organizations that receive rate/fee-based SF/SAP and are therefore unable to calculate specific costs paid with such SF/SAP, these providers may instead perform such calculations based upon their entire revenue.

This section of the Guidance is intended to: 1) assist Covered Providers in determining which individuals qualify as a Covered Executive; 2) calculate the Executive Compensation provided to each Covered Executive; and, 3) determine compliance with the Executive Compensation limitations for each Covered Executive. Guidance concerning the use of worksheets and methodologies for performing calculations is provided as a recommendation only. Regardless of the approach used by the Covered Provider, supporting documentation should be maintained to be provided to State agencies upon request.

1. Determining Which Individuals are Covered Executives

To assist Covered Providers in determining which individuals qualify as a Covered Executive, an Executive Compensation Calculation Worksheet has been developed. To use this worksheet, a Covered Provider will need to evaluate its staff with respect to their association to the Covered Provider and their role in the organization; access its original source of fiscal information; provide fiscal data for the gross executive compensation categories requested; and, at certain points in the form, may be directed to other recommended sub-processes.

The Executive Compensation Calculation Worksheet contains cells to capture specific information and performs the calculations to assist the Covered Provider. In the area of the

Executive Compensation Calculation Worksheet following section E, an evaluation of the Covered Executive's compliance with the regulatory compensation limits will be displayed.

Who to count?

Many of these potential Covered Executives have a direct relationship with the Covered Provider as compensated directors, trustees, managing partners, officers and key employees whose overall compensation exceeded \$199,000 during the CRP. Note that the regulations require that for Covered Providers with many Covered Executives, only the top ten should be counted. Covered Executives may also include those *imputed* from other related entities to the Covered Provider.

Imputed Covered Executives

In the event that a covered provider pays a related organization to perform administrative or Program Services, the Covered Executives of the related organization shall also be considered Covered Executives of the Covered Provider for purposes of reporting and compliance with the regulation, if more than 30 percent of such an imputed Covered Executive's compensation is derived from State Funds or State-authorized payments received from the covered provider.

Note: A "related organization" shall have the same meaning as that provided in Schedule R of IRS form 990, available at <http://www.irs.gov/pub/irs-pdf/i990sr.pdf>, except that for purposes of the regulation, the related organization must have received or be anticipated to receive SF/SAP payments from a covered provider during an applicable reporting period.

Note: A related organization may be a subcontractor of a covered provider, but not all subcontractors of covered providers are related organizations.

It may be helpful to think of "related organizations" as entities that are affiliates or subsidiaries or otherwise part of the covered provider's "corporate family," while a subcontractor may be any entity that contracts with a covered provider to perform a portion of the covered provider's work.

Who to exclude?

Exemptions from Covered Executive qualification exist in the regulations. Clinical or program personnel providing Program Services, including chairs of departments, heads of service, chief medical officers, directors of nursing, or similar types of personnel, who fulfill administrative functions that are directly attributable to and are comprised of Program Services, are exempt and should not be evaluated as, nor considered, Covered Executives.

Compensation excluded from the Executive Compensation calculation

Compensation that is provided pursuant to a contract entered into between a Covered Provider and a Covered Executive prior to July 1, 2012 will not be subject to the limitations contained within the regulations until the end of the term of the contract or April 1, 2015, whichever comes first. Do NOT include this compensation in the calculation of Executive Compensation.

2. Calculating Executive Compensation for Each Covered Executive

Once a Covered Provider has created a list of potential Covered Executives, the worksheet will assist in analyzing each individual to determine the compensation provided for administrative work performed, compensation provided from all sources of revenue (All Funds) and compensation provided exclusively from SF/SAP. The worksheet also helps calculate remuneration made for Program Service provision. Individuals receiving Executive Compensation (as defined in the regulations) in excess of \$199,000 in the CRP will be identified by the worksheet, thus establishing a list of Covered Executives for the Covered Provider. Note that only forms of compensation defined in the regulation as Executive Compensation should be included on the calculation worksheet.

Process

A. Enter the name and title of the potential Covered Executive

A. EXECUTIVE NAME AND TITLE					Notes	
	Prefix	First	MI	Last	Suffix	
1. Name of the potential "Covered Executive":	<input type="text"/>	a				
2. Title of the potential "Covered Executive":	<input type="text"/>					

B. Enter the CRP for which the calculation of Executive Compensation is being made for the Covered Executive/position identified.

B. COVERED REPORTING PERIOD			
	From	To	
1. Covered Reporting Period (CRP)?	<input type="text" value="mm/dd/yyyy"/>	<input type="text" value="mm/dd/yyyy"/>	b

C. Calculate the Gross Executive Compensation provided to the Covered Executive during the CRP.

C. GROSS COMPENSATION		All Funds	SF/SAP
1. Salary and wages			
2. Bonus Compensation			
3. Dividends			
4. Distributions to a shareholder/partner			
5. Other cash payments			
6. Personal vehicles			
7. Housing			
8. Below-market loans			
9. Payment of personal travel, family travel, and entertainment			
10. Personal use of organization's property			
11. Other non-cash benefits			
12. Unique executive deferred compensation and retirement plan contributions			
13. Total (total of lines C-1 through C-12)		\$ -	\$ -

D. Adjust the Gross Executive Compensation provided to the Covered Executive by excluding that compensation paid to a Covered Executive to provide Program Services.

D. PROGRAM SERVICES ADJUSTMENT	
1. Of the Total Gross Compensation calculated above, what amount was provided to render Program Services during the CRP?	<input type="text"/>

E. Determine the total amount of Executive Compensation provided to the Covered Executive during the CRP. The worksheet will automatically perform the calculations necessary.

E. TOTAL EXECUTIVE ORDER 38 COMPENSATION	\$ -
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Once a Covered Provider has determined which individuals are Covered Executives and the Executive Compensation has been calculated for each Covered Executive, a Covered

Provider must then determine whether its Covered Executives are in compliance with the limitations contained within the regulations. If a Covered Provider's Covered Executives are not compliant with the regulatory limitations, then either the Covered Provider must take action to come into compliance, or seek a waiver. If a Covered Provider does not obtain a waiver and fails to come into compliance, penalties may be imposed.

3. Compliance with the Executive Compensation Limitations

Covered Providers should maintain all records pertaining to the review of Executive Compensation in excess of the \$199,000 limitation using all sources of funding, any materials generated resulting from this review, the comparability factors considered, and the rationale used to determine the appropriateness of compensation provided. Covered Providers should be prepared to produce meeting minutes that reflect the deliberations and discussions about compensation, the date and terms of approved compensation arrangements, independence in the review process, and recusal of individuals with conflicts of interest. Such information will not only be necessary for a Covered Provider to provide to state agencies to examine upon their request, but provides necessary justification should a Covered Provider seek a waiver to the limits on Executive Compensation.

Use of SF/SAP to provide Executive Compensation

The first compliance test concerns the use of SF/SAP to provide Executive Compensation to a Covered Executive. A Covered Provider may not use more than \$199,000 in SF/SAP to provide Executive Compensation to any Covered Executive during the Covered Reporting Period, unless a waiver has been granted. Therefore, when a Covered Provider submits its EO #38 Disclosure Form, it must be able to demonstrate that it did not provide more than \$199,000 in Executive Compensation sourced exclusively from SF/SAP, or that a waiver of this requirement was granted. If a Covered Provider is unable to demonstrate that it is in compliance with this component of the regulations or unable to demonstrate that it received a waiver, it may be found in non-compliance. If non-compliance is determined, the Covered Provider will enter the Plan of Corrective Action phase, and may eventually be subject to penalties.

Use of All Revenue Sources to provide Executive Compensation

The second compliance test concerns the use of all revenue sources – not only revenue from SF/SAP – to provide Executive Compensation to a Covered Executive. Unless a waiver is granted, a Covered Provider may not provide Executive Compensation in excess of

\$199,000 during the Covered Reporting Period using any sources of revenue if either of two situations apply: 1) the Executive Compensation exceeds the 75th percentile of compensation provided to comparable executives; or 2) the Executive Compensation was not reviewed and approved by the Covered Provider's governing body, with certain conditions met. Therefore, when a Covered Provider submits its EO #38 Disclosure Form for the Covered Reporting Period, to demonstrate compliance, the Covered Provider must be able to show one of the following: 1) it did not provide more than \$199,000 in Executive Compensation from any sources of revenue (in which case it would have no Covered Executives to disclose); 2) it paid more than \$199,000 in Executive Compensation from any sources of revenue to a Covered Executive, but the Executive Compensation did not exceed the 75th percentile of that compensation provided to comparable executives **AND** that such compensation was reviewed and approved by the Covered Provider's governing body, constituted according to regulation; or, 3) it was granted a waiver authorizing the Executive Compensation provided to the Covered Executive. Stated differently, Executive Compensation from all sources of revenue may exceed \$199,000 so long as it remains below the 75th percentile of comparable executive compensation **AND** was approved by the Covered Provider's governing body, with certain requirements met. If a Covered Provider is unable to demonstrate that it is in compliance with this component of the regulations or unable to demonstrate that it received a waiver, it may be found in non-compliance. If non-compliance is determined, the Covered Provider will enter the Plan of Corrective Action phase, and may be subject to penalties.

Executive Compensation Examples

- If a Covered Executive receives more than \$199,000 in Executive Compensation, is above the 75th percentile of comparable executives, but received governing body approval, the Covered Provider would be considered non-compliant.
- If a Covered Executive receives more than \$199,000 in Executive Compensation, is below the 75th percentile of comparable executives, but did not receive governing body approval, the Covered Provider would be considered non-compliant.
- If a Covered Executive receives more than \$199,000 in Executive Compensation, is below the 75th percentile of comparable executives and received governing body approval, the Covered Provider would be considered compliant.

Determining Compensation Comparability and the 75th Percentile

To determine whether Executive Compensation provided to a Covered Executive exceeds the 75th percentile of compensation provided to comparable executives, a Covered Provider must be able to demonstrate that it reviewed appropriate comparable executives within comparable providers. Comparable providers are those that are of approximately the same size, provide approximately the same type of Program Services, and are in a comparable geographic region.

To demonstrate this, a Covered Provider may utilize a compensation survey that includes the Covered Provider's sector of Program Service, and which contains a reasonable number of comparable organizations to conduct a thorough review. Alternatively, a Covered Provider may conduct its own compensation survey.

Any compensation survey should assist the provider in examining the following factors of comparability, evidence of which may be requested of a Covered Provider when submitting an EO #38 Disclosure Form or requesting a waiver:

Factors of Comparability

Relevant factors of comparability may include, but may not be limited to, the following:

1. Similarity to other organizations in type(s) of services rendered;
2. Similarity to other organizations in scope of services rendered (i.e. number of individuals served);
3. Similarity to other organizations in size of annual budget;
4. Similarity to other organizations in number of employees;
5. Similarity to other organizations in geographic location of physical locations (e.g. offices, service locations);
6. Similarity to other organizations in geographic location of services rendered;
7. Availability of similar services within the geographic region;
8. Similarity to other executives in education levels;
9. Similarity to other executives in credentials/skills;
10. Similarity to other executives in tenure of experience;
11. Similarity to other executives in depth of experience in the field;
12. Similarity to other executives in length of time in similar positions;
13. Similarity to other executives in work schedule and level of FTE;
14. Similarity to other executives in experience in the position;
15. Similarity to other executives in performance on the job;
16. Similarity to other executives in functional comparability; and,

17. Economic climate at the time the compensation was agreed to.

When using a compensation survey, a Covered Provider should compare compensation provided to the Covered Executive using the executive compensation methodology used by the compensation survey. This will provide the most accurate comparison to the compensation provided to other executives. The methodology used by the survey may not necessarily reflect Executive Compensation as defined in the regulation. This is acceptable for the purpose of comparability.

For Covered Providers unable to procure or otherwise access an appropriate compensation survey to demonstrate whether their Covered Executive exceeds the 75th percentile of comparable executives in comparable organizations, assistance will be provided by that Covered Provider's Lead Agency.

Covered Providers should maintain all records pertaining to the use of a compensation survey, any materials generated resulting from the use of such survey, the comparability factors considered, and the rationale used to determine the appropriateness of compensation provided. Such information will not only be necessary for a Covered Provider to provide to State agencies to examine upon their request, but will likely also be necessary for justification should a Covered Provider seek a waiver to the limits on Executive Compensation.

Governing Body Review of Compensation

To determine whether Executive Compensation from all sources of revenue in excess of \$199,000 during the CRP was appropriately reviewed and approved by the Covered Provider's governing body, a Covered Provider must be able to demonstrate that such review met the criteria outlined in the regulations.

The review and approval must be conducted by the Covered Provider's board of directors or equivalent governing body, if such a governing body exists. That board of directors or equivalent governing body must include at least two independent directors or voting members.

Alternatively, a compensation committee duly authorized by the board of directors or equivalent governing body may conduct this review on behalf of the board of directors or governing body, but that compensation committee must include at least two independent directors or voting members. In the case of a compensation committee, the committee's review and approval of the Executive Compensation provided to a

Covered Executive must be reviewed and ratified by the board of directors or equivalent governing body.

Regardless of whether the board of directors or equivalent governing body or a compensation committee reviewed and approved the Executive Compensation provided to a Covered Executive, such review must include an assessment of appropriate comparability data, including consideration of the factors of comparability outlined above. This assessment must also include the following:

- An examination of all forms and sources of compensation, including salary and fringe benefits, bonuses, deferred compensation, pension and profit sharing plan contributions, etc. (NOTE: However, not all forms of compensation are included in the definition of Executive Compensation in the regulations)
- An examination of whether an employment contract with an executive would best delineate responsibilities and anticipated compensation
- An examination of comparable organizations that avoids an over-reliance on any one similar agency, but includes a larger sample of organizations
- An examination of comparable organizations and executives that measures the median rather than average

Section E.

WAIVERS

Individuals/entities seeking a waiver from either the Executive Compensation or Administrative Expenses limitations must submit a waiver request using the online waiver application found at ExecutiveOrder38.ny.gov.

ONLY THOSE INDIVIDUALS/ENTITIES THAT QUALIFY (OR PROJECT TO QUALIFY) AS A COVERED PROVIDER FOR THE CRP AND THAT EXCEED (OR PROJECT TO EXCEED) THE REGULATORY LIMITATIONS SHOULD SUBMIT A WAIVER APPLICATION.

Submission of a waiver application requires an individual/entity to determine the following information: its (projected) Covered Provider status; its (projected CRP); its (projected) SF/SAP for the CRP; and, depending on the type of waiver sought by the individual/entity, it should also have determined its (projected) Administrative Expenses, and/or its (projected) Covered Executives and (projected) Executive Compensation provided to each (projected) Covered Executive. Guidance on making these determinations is provided in the earlier sections of this guidance document.

Guidance for submission of a waiver application follows below.

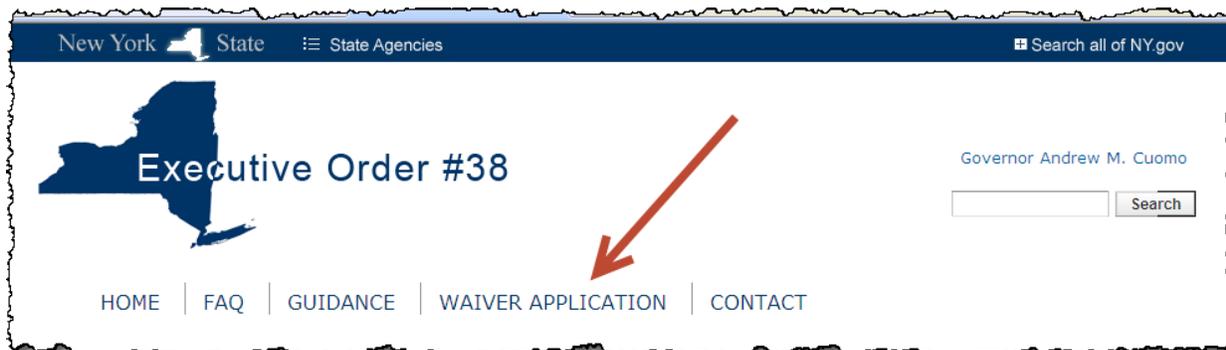
Create an EO 38 Waiver Application User Account

If an individual/entity has not done so already, it must register for an EO38 Waiver Application user account (user account). Individuals/entities that already have a user account should skip to the next section of the guidance that details the waiver application components.

ONLY ONE USER ACCOUNT SHOULD BE CREATED FOR EACH INDIVIDUAL/ENTITY.

Registration for a user account requires the submission of information about the individual/entity seeking the waiver. Once submitted, the user account registration request will be routed to the State agency identified by the individual/entity as the Lead State Agency for verification. Once verified, the individual/entity will receive an e-mail confirming that its user account has been created, allowing the individual/entity to then submit an EO 38 waiver application(s).

To register for a user account, first click “Waiver Application.”



Then, click “Request a Grants Gateway Account” to create an account.

Once the registration Form is complete and submitted, it should only take 24 hours from the date of receipt by the Grants Reform Team for the username and password to be emailed to the individual/entity.

Submitting a Waiver Application

Once an individual/entity has a Grants Gateway username and password, the individual/ entity may then proceed to complete and submit a waiver application. It should be noted that a separate waiver application must be submitted for waiver requests from the Administrative Expenses limitations and for waiver requests from the Executive Compensation limitations. For Executive Compensation waiver requests, a separate waiver application must be filed for each Covered Executive for whom a waiver is sought.

For step-by-step instructions on how to complete the waiver application, please visit the training section of the website.

Section F.

PLANS OF CORRECTIVE ACTION

AND PENALTIES

Individuals/entities that qualify as a Covered Provider that do not meet the Administrative Expenses or Executive Compensation limitations contained within the regulations, based on the State's review and analysis of the information provided by a Covered Provider on an EO 38 Disclosure, and have not been granted a waiver, will be found non-compliant. It should be noted that failure to provide a required EO #38 Disclosure, or to provide additional or clarifying information at the request of the State, may result in a determination of non-compliance.

A finding of non-compliance first requires a Covered Provider to develop and implement a Corrective Action Plan (CAP). If upon review and analysis of the information provided by a Covered Provider, the State determines that the Covered Provider has failed to properly implement and complete a CAP and remains non-compliant with the limitations of the regulations, the State agencies may then impose penalties on the Covered Provider.

Reporting – EO #38 Disclosure Submission and Review

A Covered Provider must submit an *EO #38 Disclosure* no later than 180 days after the close of the Covered Provider's CRP. Once submitted by the Covered Provider, the EO #38 Disclosure will be distributed to the State agencies from which SF/SAP was provided to the Covered Provider for review and evaluation. If, after a review period of not more than sixty (60) days, a determination is made by the State that the Covered Provider violated any of the applicable limitations on Administrative Expenses or Executive Compensation, or failed to submit the required or requested information, the Covered Provider may be considered non-compliant.

Notice of Determination of Non-Compliance

If a Covered Provider is determined to be non-compliant with the regulations, a *Notice of Determination of Non-Compliance* will be issued to the Covered Provider. The *Notice of*

Determination of Non-Compliance will be issued in writing, stating the basis for the determination of non-compliance and informing the Covered Provider of the opportunity to submit additional or clarifying information within 30 calendar days of the receipt of *Notice of Determination of Non-Compliance*.

If the Covered Provider does not submit additional or clarifying information within the time period, the *Notice of Determination of Non-Compliance* shall become final and the State will issue a *Notice to Cure*.

If the Covered Provider submits additional or clarifying information within the 30-day time period, such additional or clarifying information will be reviewed and evaluated by the involved State agencies. If, after review, the State agencies find the Covered Provider to be in compliance with the limitations of the regulation, a follow-up notice—stating that compliance by the Covered Provider was determined—will be issued to the Covered Provider. However, if, after review, the State agencies find the Covered Provider remains non-compliant, the *Notice of Determination of Non-Compliance* shall become final and a *Notice to Cure* will be issued.

Notice to Cure

Once a determination of non-compliance has been made and finalized, and a Notice of Determination of Non-Compliance issued to a Covered Provider, a *Notice to Cure* will be issued to the Covered Provider. The *Notice to Cure* will be issued to the Covered Provider in writing, articulating the basis for the determination of non-compliance, giving the Covered Provider a defined corrective action period of not less than six months within which to correct the violations identified, and requiring that the Covered Provider submit a *Corrective Action Plan* within thirty (30) calendar days of receipt of the *Notice to Cure*.

Corrective Action Plan (CAP)

A Covered Provider will receive instructions to submit a CAP in a *Notice to Cure*, after a *Notice of Determination of Non-Compliance* is issued. A CAP submitted to the State agencies should include, but may not be limited to, the following:

1. A plan that lists the specific actions – including clear, measurable steps – that will be taken by the Covered Provider to correct the identified violations;
2. A timeline or list of dates on which certain actions/milestones will be completed; and
3. The date on which the CAP will be fully implemented or completed, and the identified violations cured.

The State agencies must review and take one of the following actions with regard to the CAP within thirty (30) calendar days of receipt of the CAP:

1. Approve the CAP;
2. Request clarification from the Covered Provider; or
3. Request alterations to the CAP.

Once the CAP is approved, the State agencies will notify the Covered Provider of the approval and inform the Covered Provider of the time period for implementation, which will be 6 months in duration unless otherwise specified by the State agencies in the notice of approval or in the CAP itself. After the implementation period has concluded, the State agencies may request information from the Covered Provider to determine whether the CAP was fully and properly implemented.

If the State agencies find that the CAP was fully and properly implemented, the matter shall be considered closed and no further action on the part of the State agencies or the Covered Provider shall be required in regard to the *Determination of Non-Compliance and Notice to Cure*.

If the State agencies find that the CAP was not fully and properly implemented, the State agencies will issue a *Notice of Failure to Cure* to the Covered Provider.

Notice of Failure to Cure

If it is determined that a CAP was not fully and properly implemented, a *Notice of Failure to Cure* will be issued to the Covered Provider. The *Notice of Failure to Cure* will be issued to the Covered Provider in writing, articulating the basis for the conclusion that the CAP was not fully and properly implemented, including a statement from the State agencies demonstrating that the totality of the circumstances (including the seriousness of the violations, the nature of the Covered Provider's services, and the Covered Provider's efforts to correct the violations) were taken into consideration, and identifying any additional actions to be taken against the Covered Provider. Such additional actions resulting from a *Notice of Failure to Cure* may include modifications to the CAP or the CAP's implementation period, or issuance of a *Notice of Sanctions Due to Non-Compliance*.

Notice of Sanctions Due to Non-Compliance

The *Notice of Sanctions Due to Non-Compliance* issued as part of a *Notice of Failure to Cure* will state the violations identified but not corrected, and provide notice of the sanctions that the State agencies intend to impose on the Covered Provider. Such sanctions may include one or more of the following:

1. Redirection of SF/SAP for Program Services;
2. Suspension, modification, limitation, or revocation of the Covered Provider's license(s), certification or permission to provide Program Services;
3. Suspension, modification, limitation or revocation of contracts or other agreements with the Covered Provider; and/or
4. Any other lawful actions or penalties deemed appropriate by the State agencies, including letters of reprimand, findings of non-responsibility, referral to investigation or law enforcement officials for potential investigation/legal action.

Opportunity for Appeal

Within thirty (30) calendar days of a Covered Provider's receipt of a *Notice of Failure to Cure* and *Notice of Sanctions Due to Non-Compliance*, a Covered Provider may request an administrative appeal. Such an appeal request must be submitted in writing, contain a detailed explanation of the legal and factual bases for the Covered Provider's challenge to the determination, and include any documentation to support the Covered Provider's position. Such an appeal request will be limited to an administrative review of the record, unless the State agencies seek to impose a sanction for which an administrative hearing is required.

If such a request for appeal is not submitted within thirty (30) calendar days, the *Notice of Failure to Cure* will become final and the sanctions outlined in the *Notice of Sanctions Due to Non-Compliance* will then be imposed on the Covered Provider.

If a request for appeal is submitted within 30 calendar days, the State agencies will perform an administrative review of the record (or, if required by applicable law, provide an administrative hearing) and render a determination on the request for appeal. Once completed, the State agencies will issue a decision on the appeal to the Covered Provider, stating the findings of fact and conclusions of law that support the determination on the appeal. If the Covered Provider is found to be non-compliant pursuant to the decision on the appeal, the sanctions will then be imposed on the Covered Provider.

APPENDICES

Appendix A.

Definitions

Administrative Expenses are those expenses authorized and allowable pursuant to applicable agency regulations, contracts or other rules that govern reimbursement with State funds or State-authorized payments that are incurred in connection with the covered provider's overall management and necessary overhead that cannot be attributed directly to the provision of program services.

- (1) Such expenses include but are not limited to the following expenses, if otherwise authorized and allowable pursuant to applicable agency regulations, contracts or other rules that govern reimbursement with State funds or State-authorized payments:
 - (i) that portion of the salaries and benefits of staff performing administrative and coordination functions that cannot be attributed to particular program services, including but not limited to the executive director or chief executive officer, financial officers such as the chief financial officer or controller and accounting personnel, billing, claiming or accounts payable and receivable personnel, human resources personnel, public relations personnel, administrative office support personnel, and information technology personnel, where such expenses cannot be attributed directly to the provision of program services;
 - (ii) that portion of legal expenses that cannot be attributed directly to the provision of program services; and
 - (iii) that portion of expenses for office operations that cannot be attributed directly to the provision of program services, including telephones, computer systems and networks, professional and organizational dues, licenses, permits, subscriptions, publications, audit services, postage, office supplies, conference expenses, publicity and annual reports, insurance premiums, interest charges and equipment that is expensed (rather than depreciated) in cost reports, where such expenses cannot be attributed directly to the provision of program services.
- (2) Administrative expenses do not include:

- (i) capital expenses, including but not limited to non-personal service expenditures for the purchase, development, installation, and maintenance of real estate or other real property; or
- (ii) property rental, mortgage or maintenance expenses; or
- (iii) taxes, payments in lieu of taxes, or assessments paid to any unit of government; or
- (iv) equipment rental, depreciation and interest expenses, including expenditures for vehicles and fixed, major movable and adaptive equipment and equipment that is expensed (rather than depreciated) in cost reports; or
- (v) expenses of an amount greater than \$10,000 that would otherwise be administrative, except that they are either non-recurring (no more frequent than once every five years) or not anticipated by a covered provider (e.g., litigation-related expenses). Such expenses shall not be considered administrative expenses or program expenses for purposes of this regulation; or
- (vi) that portion of the salaries and benefits of staff performing policy development or research.

Covered executive is a compensated director, trustee, managing partner, or officer whose salary and/or benefits, in whole or in part, are administrative expenses, and any key employee whose salary and/or benefits, in whole or in part, are administrative expenses and whose executive compensation during the reporting period exceeded \$199,000. For the purposes of this definition, the terms “director,” “trustee,” “officer,” and “key employee” shall have the same meaning as such terms in the Internal Revenue Service’s instructions accompanying Form 990, Part VII. If the number of key employees employed by the covered provider who meet this definition exceeds ten, then the covered provider shall report only those ten key employees whose executive compensation is the greatest during the reporting period and no other key employees shall be considered covered executives. Clinical and program personnel in a hospital or other entity providing program services, including chairs of departments, heads of service, chief medical officers, directors of nursing, or similar types of personnel fulfilling administrative functions that are nevertheless directly attributable to and comprise program services shall not be considered covered executives for purposes of limiting the use of State funds or State-authorized payments to compensate them. In the event that a covered provider pays a related organization to perform administrative or program services, the covered executives of the

related organization shall also be considered “covered executives” of the covered provider for purposes of reporting and compliance with these regulations if more than thirty (30) percent of such a covered executive’s compensation is derived from State funds or State-authorized payments received from the covered provider. In such a circumstance, the related organization shall not be subject to the limitations on the use of State funds or State-authorized payments for administrative expenses in Section 513.4 of this Part solely as a result of having covered executives.

Covered Operating Expenses shall mean the sum of program services expenses and administrative expenses of a covered provider as defined in subdivision (d) of this section.

Covered Provider

(1) A “covered provider” is an entity or individual that:

- (i) has received pursuant to contract or other agreement with the Office, or with another governmental entity, including county and local governments, or an entity contracting on its behalf, to render program services, State funds or State-authorized payments during the covered reporting period and the year prior to the covered reporting period, and in an average annual amount greater than \$500,000 during those two years; and
- (ii) at least thirty (30) percent of whose total annual in-state revenues for the covered reporting period and for the year prior to the covered reporting period were derived from State funds or State-authorized payments. This percentage shall be calculated as a percentage of the total annual revenues derived from and in connection with the provider’s activities within New York State, irrespective of whether the provider derives additional revenues from activities in another state. The source of such revenues shall include those from sources outside New York State if such revenues were derived from or in connection with activities inside New York State, including, for example, contributions by out-of-state individuals or entities for in-state activities. Where applicable, a provider’s method of calculating in-state revenues for purposes of determining tax liability or in connection with completion of its financial statements shall be deemed acceptable by the Office for the purpose of applying this subparagraph.

(2) For purposes of this Part:

- (i) An entity or individual that receives State funds or State-authorized payments directly from a managed care organization that is subject to the oversight of the Office or another governmental entity shall be deemed to receive State funds or State-authorized payments pursuant to contract or other agreement with the Office, or with another governmental entity, to render program services, and
 - (ii) The method of accounting used by the entity or individual in the preparation of its annual financial statements shall be used, except that an entity or individual that otherwise reports to the Office using a different method of accounting shall use such method.
- (3) The following providers shall not be considered covered providers:
- (i) State, county, and local governmental units in New York State, and tribal governments for the nine New York State recognized nations, and any subdivisions or subsidiaries of the foregoing entities;
 - (ii) Individuals or entities providing child care services who are in receipt of child care subsidies pursuant to Title 5-C or Section 410 of the Social Services Law, except that such providers may be considered covered providers if they also receive State funds or State-authorized payments that are not child care subsidies pursuant to Title 5-C or Section 410 of the Social Services Law and would otherwise satisfy the criteria in this definition;
 - (iii) Individual professional(s), partnerships, S Corporations, or other entities, at least seventy-five percent of whose program services paid for by State funds or State-authorized payments are provided by the individual professional(s), by the partner(s), or by the owner(s) of the corporation or entity, rather than by employees or independent contractors employed or retained by the entity, as determined by the amounts obtained in State funds or State-authorized payments for such program services;
 - (iv) Individuals or entities providing primarily or exclusively products, rather than services, in exchange for State funds or State-authorized payments, including but not limited to pharmacies and medical equipment suppliers. For the purpose of applying this exception, the percentage of revenues derived from products rather than from services shall be used; and

- (v) Entities within the same corporate family as a covered provider, including parent or subsidiary corporations or entities, except where such a corporation or entity would otherwise qualify as a covered provider but for the fact that it has received its State funds or State-authorized payments from a covered provider rather than directly from a governmental agency.

Covered Reporting Period shall mean the provider's most recently completed annual reporting period, as defined herein, commencing on or after July 1, 2013.

Director shall mean, unless otherwise provided, a member of the organization's governing body at any time during the tax year, but only if the member has any voting rights. A member of an advisory board that does not exercise any governance authority over the organization is not considered a director or trustee. See IRS Instructions for Form 990, Part VII for examples and additional guidance.

Executive Compensation shall include all forms of cash and noncash payments or benefits given directly or indirectly to a covered executive, including but not limited to salary and wages, bonuses, dividends, distributions to a shareholder/partner from the current reporting period's earnings where such distributions represent compensatory or guaranteed payments or compensatory partnership profits allocation or compensatory partnership equity interest for services rendered during such reporting period, and other financial arrangements or transactions such as personal vehicles, housing, below-market loans, payment for personal or family travel, entertainment, and personal use of the organization's property, reportable on a covered executive's W-2 or 1099 form, except that mandated benefits (e.g., Social Security, worker's compensation, unemployment insurance and short-term disability insurance), and other benefits such as health and life insurance premiums and retirement and deferred compensation plan contributions that are consistent with those provided to the covered provider's other employees shall not be included in the calculation of executive compensation. For the purposes of this definition, such benefits shall be considered consistent with those provided to other employees where the intended value of the benefit is substantially equal, even where the cost to the covered provider to provide such a benefit may differ. With respect to employer contributions to retirement and deferred compensation plans that are not consistent with those provided to other employees, executive compensation shall be deemed to include only those amounts contributed or accrued during the reporting period for the

benefit or intended benefit of the covered executive, even if not reported on the executive's W-2 or 1099 for that reporting period (but not those amounts that vested during such period but were contributed or accrued prior to the period).

Key Employee means an employee of an organization (other than an officer, director, or trustee) who meets all three of the following tests applied in the following order: (1) \$150,000 Test. Receives reportable compensation from the organization and all related organizations in excess of \$150,000 for the calendar year ending with or within the organization's tax year; (2) Responsibility Test. The employee: a. has responsibilities, powers or influence over the organization as a whole similar to those of officers, directors, or trustees; b. manages a discrete segment or activity of the organization that represents 10% or more of the activities, assets, income, or expenses of the organization, as compared to the organization as a whole; or c. has or shares authority to control or determine 10% or more of the organization's capital expenditures, operating budget, or compensation for employees; and (3) Top 20 Test. Is one of the 20 employees (that satisfy the \$150,000 Test and Responsibility Test) with the highest reportable compensation from the organization and related organizations for the calendar year ending with or within the organization's tax year? See IRS instructions for Form 990, Part VII for examples of key employees.

Officer means, unless otherwise provided, a person elected or appointed to manage the organization's daily operations at any time during the tax year, such as a president, vice-president, secretary, treasurer, and, in some cases, Board Chair. The officers of an organization are determined by reference to its organizing document, bylaws, or resolutions of its governing body, or as otherwise designated consistent with state law, but at a minimum include those officers required by applicable state law. For purposes of Form 990 as well as EO#38, treat the organization's top management official and top financial official as officers. See IRS Instructions for Form 990, Part VII for examples and additional guidance.

Program Services are those services rendered by a covered provider or its agent directly to and for the benefit of members of the public (and not for the benefit or on behalf of the State or the awarding agency) that are paid for in whole or in part by State funds or State-authorized funds. Program services shall not include:

- (1) policy development or research; or

(2) staffing or other assistance to a State agency or local unit of government in such agency's or government's provision of services to members of the public.

Program Services Expenses are those expenses authorized and allowable pursuant to applicable agency regulations, contracts or other rules that govern reimbursement with State funds or State-authorized payments that are incurred by a covered provider or its agent in direct connection with the provision of program services.

- (1) Such expenses include but are not limited to the following expenses, if otherwise authorized and allowable pursuant to applicable agency regulations, contracts or other rules that govern reimbursement with State funds or State-authorized payments:
 - (i) that portion of the salaries and benefits of staff providing particular program services, including for example, employees or contractors providing direct care to clients, and supervisory personnel and support personnel whose work is attributable to a specific program in whole or in part and contributes directly to the quality or scope of the program services provided;
 - (ii) that portion of the salaries and benefits of quality assurance and supervisory personnel whose work is attributable in whole or in part to particular programs and contributes to the quality or scope of the program services provided by other personnel and related expenses; and
 - (iii) that portion of expenses incurred in connection with and attributable to the provision of particular program services, including for example, travel costs to and from client residences, direct care supplies, public outreach or education or personnel training to facilitate program services delivery, information technology and computer services and systems directly attributable to program services such as, for example, electronic patient records systems to facilitate improved patient care or computer systems used in program services delivery or documentation of program services provided, quality assurance and control expenses, and legal expenses necessary to accomplish particular program service objectives.
- (2) Program services expenses do not include:
 - (i) capital expenses, including but not limited to non-personal service expenditures for the purchase, development, installation, and maintenance of real estate or other real property; or

- (ii) property rental, mortgage or maintenance expenses, except where such expenses are made in connection with providing housing to members of the public receiving program services from the covered provider; or
- (iii) taxes, payments in lieu of taxes, or assessments paid to any unit of government; or
- (iv) equipment rental, depreciation and interest expenses, including expenditures for vehicles and fixed, major movable and adaptive equipment and equipment that is expensed (rather than depreciated) in cost reports; or
- (v) expenses of an amount greater than \$10,000 that would otherwise be administrative, except that they are either non-recurring (no more frequent than once every five years) or not anticipated by a covered provider (e.g., litigation-related expenses). Such expenses shall not be considered administrative expenses or program expenses for purposes of this regulation; or
- (vi) that portion of the salaries and benefits of staff performing policy development or research.

Related Organization shall have the same meaning as the same term in Schedule R of the Internal Revenue Service's Form 990 except that for purposes of this regulation a related organization must have received or be anticipated to receive State funds or State-authorized payments from a covered provider during the reporting period.

Reporting Period shall mean, at the provider's option, the calendar year or, where applicable, the fiscal year used by a provider. However, where a provider is required to file an annual Cost Report with the State, *reporting period* shall mean the reporting period applicable to said Cost Report.

State-Authorized Payments refer to those payments of funds that are not State funds but which are distributed or disbursed upon a New York state agency's approval or by another governmental unit within New York State upon such approval, including but not limited to the federal and county portions of Medicaid program payments approved by the state agency. The

Office shall publish a list of government programs whose funds shall be considered State-authorized payments prior to the effective date of this regulation. For purposes of this regulation, State-authorized payments shall not include any payments solely for the following purposes:

- (1) procurement contracts awarded on a “lowest price” basis pursuant to section 163 of the State Finance Law;
- (2) awards to State or local units of government except to the extent such funds or payments are used by such government unit to pay covered providers to provide program services through a contract or other agreement;
- (3) capital expenses, including but not limited to non-personal service expenditures for the purchase, development, installation, and maintenance of real estate or other real property, or equipment;
- (4) direct payments of State funds or State-authorized payments, or provision of vouchers or other items of monetary value that may be used to secure specific services selected by the individual, or health insurance premiums including but not limited to New York State Health Insurance Program (NYSHIP) premium payments, or Supplemental Security Income (SSI) payments, to or on behalf of individual members of the public;
- (5) wage or other salary subsidies paid to employers to support the hiring or retention of their employees;
- (6) awards to for-profit corporations or other entities engaged exclusively in commercial or manufacturing activities and not in the provision of program services;
- (7) policy development or research; or
- (8) funds expressly intended to pay exclusively for administrative expenses, including but not limited to Community Service Program “core” contract funding for HIV/AIDS services programs.

State Funds are those funds appropriated by law in the annual state budget pursuant to Article VII, Section 7 of the New York State Constitution. The Office shall publish a list of government programs whose funds shall be considered State funds prior to the effective date of this regulation. For purposes of this Part, State funds shall not include any payments solely for the following purposes:

- (1) procurement contracts awarded on a “lowest price” basis pursuant to section 163 of the State Finance Law;
- (2) awards to State or local units of government except to the extent such funds or payments are used by such government unit to pay covered providers to provide program services through a contract or other agreement;
- (3) capital expenses, including but not limited to non-personal service expenditures for the purchase, development, installation, and maintenance of real estate or other real property, or equipment;
- (4) direct payments of State funds or State-authorized payments, or provision of vouchers or other items of monetary value that may be used to secure specific services selected by the individual, or health insurance premiums including but not limited to New York State Health Insurance Program (NYSHIP) premium payments, or Supplemental Security Income (SSI) payments, to or on behalf of individual members of the public;
- (5) wage or salary subsidies paid to employers to support the hiring or retention of their employees;
- (6) awards to for-profit corporations or other entities engaged exclusively in commercial or manufacturing activities and not in the provision of program services;
- (7) policy development or research; or
- (8) funds expressly intended to pay exclusively for administrative expenses, including but not limited to Community Service Program “core” contract funding for HIV/AIDS services programs.

Trustee shall mean, unless otherwise provided, a member of the organization's governing body at any time during the tax year, but only if the member has any voting rights. A member of an advisory board that does not exercise any governance authority over the organization is not considered a director or trustee. See IRS Instructions for Form 990, Part VII for examples and additional guidance.

Appendix B.

Government Programs

Using the Executive Order #38 Government Programs List to Calculate State Funds/State-Authorized Payments - *This guidance is intended to accompany the list of Government Programs to which Executive Order #38 and the related regulations apply*

If an individual/entity receives funding in connection with the provision of Program Services to members of the public, those funds should be verified to determine whether they were provided pursuant to a Government Program. A consolidated list of identified Government Programs, organized by the agencies to which EO #38 applies and which have filed regulations to implement EO #38, has been compiled and follows below. This list may not be all-inclusive and will be updated as changes occur. If an individual/entity receives State Funds/State-Authorized Payments (SF/SAP) in connection with providing Program Services to members of the public and is unsure whether such funds are captured on the existing list of Government Programs, it is incumbent upon the provider to seek clarification with the agency for which they are providing such Program Services. Individuals/entities can use this list to help determine the amount of SF/SAP they receive, and thereby determine whether or not they may be considered a Covered Provider. For Covered Providers, the calculation of SF/SAP will be a necessary threshold calculation to determine compliance with the limitations on executive compensation and administrative expenses.

Using this list, and depending on the funding structures and accounting methods used by each individual/entity, an individual/entity may calculate the amount of SF/SAP received from each listed Government Program, or may calculate SF/SAP received based on a calculation of all funding received from each listed State agency. In either case, individuals/entities should keep on file any materials that were generated in the process of calculating the amount of SF/SAP received, and thereby used in determining the organization's Covered Provider status.

For example, funds that should be examined to determine whether they are SF/SAP could include:

- funds passed-through a county or local government
- funds received through other non-governmental organizations
- funds received from or passed-through Medicaid Managed Care organization

- total Medicaid reimbursement

Calculating SF/SAP - A provider may calculate its SF/SAP by conducting a government program-by-government program funding analysis or by conducting a state agency-by-state agency funding analysis.

By Government Program

To determine the SF/SAP received from each government program, first a provider must identify the Covered Reporting Period (as defined by regulation) and the period prior for which they are calculating SF/SAP. Then, a provider must determine from which of the published government programs it received funding to render program services during the applicable Reporting Period. Because funding provided for certain specified purposes is exempted from the calculation of SF/SAP, a provider should determine what amount, if any, was received:

- 1) solely from a procurement contract awarded on a “lowest price” basis pursuant to section 163 of the State Finance Law (e.g. Invitation for Bids [IFB]);
- 2) solely for an award to a State or local unit of government except to the extent such funds or payments were used by such government entity to pay covered providers to provide program services through a contract or other agreement;
- 3) solely for capital expenses, including but not limited to non-personal service expenditures for the purchase, development, installation, and maintenance of real estate or other real property, or equipment;
- 4) solely for a direct payment of state funds or state-authorized payments, or provision of vouchers or other items of monetary value that may be used to secure specific services selected by the individual, or health insurance premiums including but not limited to NYSHIP premium payments, or Supplemental Security Income (SSI) Payments, to or on behalf of individual members of the public (e.g. Women, Infant and Children [WIC]), Food Stamps)
- 5) solely for wage or salary subsidies paid to employers to support the hiring or retention of their employees (e.g. OPWDD Healthcare Enhancement);
- 6) solely for an award to a for-profit corporation or other entities engaged exclusively in commercial or manufacturing activities and not in the provision of program services (e.g. pharmaceutical manufacturers and distributors, durable medical equipment manufacturers and distributors);

7) solely for policy development or research; and,

8) expressly intended to pay exclusively for administrative expenses (e.g. Community Service Program “core” contract funding for HIV/AIDS services programs, Community Service Block Grant Program technical assistance contract funding for board development).

The amounts identified in 1-8 above should be excluded from the total amount of SF/SAP received by a provider from the listed government program for the provision of program services in the applicable reporting period(s). This calculation process should be repeated for each government program in each state agency from which an organization received funding in the applicable Reporting Period(s).

By State Agency

In some cases, providers may wish to take the entire amount of funding they received from a listed state agency and determine which of that was provided for program services for the applicable reporting periods in order to calculate the amount of SF/SAP received. Using this approach, a provider should determine each of those listed state agencies from which (or through which) it received funding to render program services during the applicable reporting period. For each state agency selected, the provider should determine the amount of funds it received from or through that state agency to render program services during the applicable Reporting Period. Because funding provided for certain specified purposes is exempted from the calculation of SF/SAP, a provider should determine what amount, if any, was received:

- 1) solely from a procurement contract awarded on a “lowest price” basis pursuant to section 163 of the State Finance Law (e.g. Invitation for Bids [IFB]);
- 2) solely for an award to a State or local unit of government except to the extent such funds or payments were used by such government entity to pay covered providers to provide program services through a contract or other agreement;
- 3) solely for capital expenses, including but not limited to non-personal service expenditures for the purchase, development, installation, and maintenance of real estate or other real property, or equipment;
- 4) solely for a direct payment of state funds or state-authorized payments, or provision of vouchers or other items of monetary value that may be used to secure specific services selected by the individual, or health insurance premiums including by not limited to NYSHIP premium payments, or Supplemental Security Income (SSI) Payments, to or on behalf of individual members of the public (e.g. Women, Infant and Children [WIC]), Food Stamps)

5) solely for wage or salary subsidies paid to employers to support the hiring or retention of their employees (e.g. OPWDD Healthcare Enhancement);

6) solely for an award to a for-profit corporation or other entities engaged exclusively in commercial or manufacturing activities and not in the provision of program services (e.g. pharmaceutical manufacturers and distributors, durable medical equipment manufacturers and distributors);

7) solely for policy development or research; and,

8) expressly intended to pay exclusively for administrative expenses (e.g. Community Service Program “core” contract funding for HIV/AIDS services programs, Community Service Block Grant Program technical assistance contract funding for board development).

The amounts identified in 1-8 above should be excluded from the total amount of SF/SAP received by a provider from the listed government program for the provision of program services in the applicable reporting period(s). This calculation process should be repeated for each state agency from which an organization received funding in the applicable reporting period(s).

Agriculture & Markets

Agribusiness Child Development

Farm Family Assistance

Department of Corrections and Community Supervision (2012-13)

State General Fund-Health Services Program, including: Physician Services; Dialysis; Regional Medical Unit; Radiology Services; Nursing Services; Dental Services; Hospital Secure Ward; AIDS-Specialty Care; Outside Hospital – Outpatient; Outside Hospital – Emergency Room; Outside Hospital – Mental Health

State General Fund-Program Services Program, including: Alcohol and Substance Abuse Treatment; Medicaid Enrollment Legal Assistance; Visitors Centers; Nursery Program; Parenting Program; Family Services; Pediatric Healthcare; Creative Arts Program; Domestic Violence Program; Victim Services; Sex Offender Program; Transitional Services; Occupation Therapy; Family Reunion Program; Enhanced AIDS Education; Academic and Vocational Education;

Special Revenue Fund-Federal Dept of Education Account College Program; Academic and Vocational Education;

Special Revenue Fund-Federal Operating Grants Fund-Alcohol and Substance Abuse Treatment

State General Fund-Community Supervision Program, including Center for Employment Opportunities-Vocational Development Project; Community-based Residential Programs; Residential Stabilization Programs; Employment Program; Parole Violator Diversion Program;

Internal Service Fund- Community Supervision Program, including: Neighborhood Work Project; Center for Employment Opportunities

Department of Corrections and Community Supervision (2013-14)

State General Fund-Health Services Program, including: Physician Services; Dialysis; Regional Medical Unit; Radiology Services; Nursing Services; Dental Services; Hospital Secure Ward; AIDS-Specialty Care; Outside Hospital – Outpatient; Outside Hospital – Emergency Room; Outside Hospital – Mental Health

State General Fund-Program Services Program, including: Alcohol and Substance Abuse Treatment; Medicaid Enrollment Legal Assistance; Visitors Centers; Nursery Program; Parenting Program; Family Services; Pediatric Healthcare; Creative Arts Program; Victim Services; Sex Offender Program; Transitional Services; Occupation Therapy; Family Reunion Program; Enhanced AIDS Education; Academic and Vocational Education;

Special Revenue Fund-Federal Department of Education Account College Program; Academic and Vocational Education;

Special Revenue Fund-Federal Operating Grants Fund-Alcohol and Substance Abuse Treatment;

State General Fund-Community Supervision Program, including Center for Employment Opportunities-Vocational Development Project; Community -based Residential Programs; Residential Stabilization Programs; Employment Program;

Internal Service Fund- Community Supervision Program Center for Employment Opportunities-Neighborhood Work Project

Department of Corrections and Community Supervision (2014-15)

State General Fund-Health Services Program, including: Physician Services; Dialysis; Regional Medical Unit; Radiology Services; Nursing Services; Dental Services; Hospital Secure Ward; AIDS-Specialty Care; Outside Hospital – Outpatient; Outside Hospital – Emergency Room; Outside Hospital – Mental Health

State General Fund-Program Services Program, including: Alcohol and Substance Abuse Treatment; Medicaid Enrollment Legal Assistance; Visitors Centers; Nursery Program; Parenting Program; Family Services; Pediatric Healthcare; Creative Arts Program; Victim Services; Sex Offender Program; Transitional Services; Occupation Therapy; Family Reunion Program; Enhanced AIDS Education; Academic and Vocational Education;

Special Revenue Fund-Federal Department of Education Account College Program; Academic and Vocational Education;

Special Revenue Fund-Federal Operating Grants Fund-Alcohol and Substance Abuse Treatment;

State General Fund-Community Supervision Program, including Center for Employment Opportunities-Vocational Development Project; Community -based Residential Programs; Residential Stabilization Programs; Employment Program;

Internal Service Fund- Community Supervision Program Center for Employment Opportunities-Neighborhood Work Project

Department of Corrections and Community Supervision (2015-16)

State General Fund-Health Services Program, including: Physician Services; Dialysis; Regional Medical Unit; Radiology Services; Nursing Services; Dental Services; Hospital Secure Ward; AIDS-Specialty Care; Outside Hospital – Outpatient; Outside Hospital – Emergency Room; Outside Hospital – Mental Health

State General Fund-Program Services Program, including: Alcohol and Substance Abuse Treatment; Medicaid Enrollment Legal Assistance; Visitors Centers; Nursery Program; Parenting Program; Family Services; Pediatric Healthcare; Creative Arts Program; Victim Services; Sex Offender Program; Transitional Services; Enhanced AIDS Education; Academic and Vocational Education; Family Reintegration; Speech and Language Pathologists

Special Revenue Fund-Federal Department of Education Account College Program; Academic and Vocational Education;

Special Revenue Fund-Federal Operating Grants Fund-Alcohol and Substance Abuse Treatment; Prison Rape Elimination Act Prevention and Education

State General Fund-Community Supervision Program, including Center for Employment Opportunities-Vocational Development Project; Community -based Residential Programs; Residential Stabilization Programs; Employment Program; Reentry Courts

Internal Service Fund- Community Supervision Program Center for Employment Opportunities- Neighborhood Work Project

<u>Department of Health</u>				
Programs	State Budget Years			
An "X" denotes the presence of the program in the State Budget for the year.	2012-2013	2013-2014	2014-2015	2015-2016
<u>Office of Health Information Technology Transformation</u>				
Health e-link	X	X	X	X
<u>Division of Legal Affairs</u>				
Professional Medical Conduct Account	X	X	X	X
<u>Public Affairs Group</u>				
Cable Television Account	X	X	X	X
<u>Office of Primary Care</u>				
Empire Clinical Research Investigation Program (ECRIP)	X	X	X	X
NYS Area Health Education Center	X	X	X	X
Ambulatory Care Training Program	X	X	X	X
Physician Loan Repayment Program	X	X	X	X
Physician Practice Support Program	X	X	X	X
Physician Workforce Studies	X	X	X	X
Diversity in Medicine/Post-Baccalaureate Program	X	X	X	X
<u>Office of Minority Health</u>				
Office of Minority Health COLA	X	X	X	X
Office of Minority Health	X	X	X	X
<u>Division of Administration</u>				
Administration Program Accounts	X	X	X	X
SPARCS Account	X	X	X	X
Vital Records Management	X	X	X	X

<u>Department of Health</u>				
Programs	State Budget Years			
An "X" denotes the presence of the program in the State Budget for the year.	2012-2013	2013-2014	2014-2015	2015-2016
<u>Office of Health Systems Management</u>				
Sub allocation to the Office of Mental Health for surveys of psychiatric residential treatment facilities	X	X	X	X
Home Health Aide Registry	X	X	X	X
Quality of Care Revenue UR	X	X	X	X
NYPORIS	X	X	X	X
Health Information Technology	X	X	X	X
Liver Transplant and Alliance for Donation	X	X	X	X
Patient Health Information	X	X	X	X
Cardiac Services Access	X	X	X	X
Brain Trauma Foundation	X	X	X	X
NYS Donor Registry Statewide Campaign	X	X	X	X
Adult Care Facilities Quality Program	X	X	X	X
Enriched Housing	X	X	X	X
Long Term Care Community Coalition Advocacy Program	X	X	X	X
Emergency Medical Services	X	X	X	X
Health Care Delivery Administration	X	X	X	X
Health Occupation Development and Workplace Demo	X	X	X	X
Primary Care Initiatives	X	X	X	X
Hospital and Nursing Home Management	X	X	X	NOT INCLUDED
Certificate of Need	X	X	X	X
Funeral Directing	X	X	X	X
Patient Safety Center	X	X	X	X
Professional Medical Conduct	X	X	X	X
Adult Home Quality Enhancement	X	X	X	X
Continuing Care Retirement Community	X	X	X	X
Nurse Aide Registry	X	X	X	X
Quality of Care Improvement	X	X	X	X
Quality Program Adult Care Facilities Health Care Reform Act	X	X	X	X

Department of Health

Programs	State Budget Years			
	2012-2013	2013-2014	2014-2015	2015-2016
An "X" denotes the presence of the program in the State Budget for the year.				
Health Workforce Retraining	X	X	X	X
Rural Health Care Access	X	X	X	X
Rural Health Network Development	X	X	X	X
Health Facility Restructuring Program Transfer to D.A.	X	X	X	X
Auditing of Hospital Compliance, including Forge Proof Prescriptions	X	X	X	X
Upstate Poison Control Center	NOT INCLUDED	X	NOT INCLUDED	NOT INCLUDED
Coalition for then Institutionalized Aged and Disabled CCH	NOT INCLUDED	X	X	X
Life – Pass It On	NOT INCLUDED	NOT INCLUDED	X	X
Upstate Medical University	NOT INCLUDED	NOT INCLUDED	X	X
Distressed hospital transition fund	NOT INCLUDED	NOT INCLUDED	X	X
Finger Lake Health System Agency CCH	NOT INCLUDED	NOT INCLUDED	X	X
Coalition for the Institutionalized Aged and Disabled	NOT INCLUDED	NOT INCLUDED	X	X
Health Resources and Services Administration Grant	NOT INCLUDED	NOT INCLUDED	X	X
<u>Office of Health Insurance Programs</u>				
Evaluation of Partnership and FSHRP Waiver Program	X	X	NOT INCLUDED	NOT INCLUDED
Creation of a State Enrollment Portal	X	NOT INCLUDED	NOT INCLUDED	X
Hospital Institutional Cost Report	X	X	X	X
Center for Workforce Studies	X	X	X	X
Minority Participation in Medical Education	X	X	X	X
Gateway Institute for Minority Participation in Medical Education	X	X	X	X

Department of Health

Programs	State Budget Years			
	2012-2013	2013-2014	2014-2015	2015-2016
An "X" denotes the presence of the program in the State Budget for the year.				
Pharmacy Best Practices	X	X	NOT INCLUDED	X
Utilization Review Activities	X	X	NOT INCLUDED	X
Improvement in the Long Term Care systems	X	X	X	X
Criminal Background Checks	X	X	X	X
Utilization Management and Health Information Technology Support	X	X	X	X
Audits of disproportionate Share Hospital Programs	X	X	X	X
SSHSP Audit	X	X	NOT INCLUDED	NOT INCLUDED
Decreasing Pressure Ulcers	X	X	NOT INCLUDED	X
School Supportive Health Services	X	X	X	X
Automated Eligibility Systems	X	X	NOT INCLUDED	NOT INCLUDED
Care Management and Benefit Expansion	X	X	NOT INCLUDED	NOT INCLUDED
Data Collection to Measure Disparities	X	X	NOT INCLUDED	NOT INCLUDED
Fair Hearings	X	NOT INCLUDED	NOT INCLUDED	NOT INCLUDED
Enrollment Assistors	X	X	NOT INCLUDED	NOT INCLUDED
Primary Care Service Corps	X	X	NOT INCLUDED	X
Medicaid Analysis and Exchange Activities	X	NOT INCLUDED	NOT INCLUDED	NOT INCLUDED
Certificate of Public Advantage Program	X	X	NOT INCLUDED	NOT INCLUDED
Studies, reviews and Analysis on Medicaid	X	X	X	X

Department of Health

Programs	State Budget Years			
	2012-2013	2013-2014	2014-2015	2015-2016
An "X" denotes the presence of the program in the State Budget for the year.				
Uniform Assessment Program	X	X	X	X
Traumatic Brain Injury	X	X	X	X
Housing Subsidies NHTDW	X	X	X	X
Alzheimer's Disease Assistance Centers	X	X	X	X
Alzheimer's Coalition of New York State	X	X	X	X
Alzheimer's Community Assistance Program	X	X	X	X
Alzheimer's Community Service Programs	X	X	X	X
Alzheimer's Disease Coordinating Patient Care	X	X	X	X
Falls Prevention Program	X	X	X	X
Children's Health Insurance Account	X	X	X	X
Children's Health Insurance Account Aid to Localities	X	X	X	X
Elderly Pharmaceutical Insurance Coverage Program State Operations	X	X	X	X
Elderly Pharmaceutical Insurance Coverage Program Aid to Localities	X	X	X	X
Provider Collection Monitoring	X	X	X	X
Hospital and Nursing Home Management	X	NOT INCLUDED	NOT INCLUDED	NOT INCLUDED
Medicaid Fraud Hotline and Medical Administration	X	X	X	X
Medical Assistance - Fee for service Medicaid and Managed Care Medicaid	X	X	X	X
Pilot Health Insurance	X	X	X	X
Alzheimer's Research	X	X	X	X
Assisted Living Residence Quality Oversight	X	X	X	X
Audit Contracts for Payor and Provider Compliance	X	X	X	X
Pool Administration	X	X	X	X
Poison Control Center	X	X	X	X

Department of Health

Programs	State Budget Years			
	2012-2013	2013-2014	2014-2015	2015-2016
An "X" denotes the presence of the program in the State Budget for the year.				
Disease Management	X	X	X	X
DC27 and Teamster Local 858 Health Insurance	NOT INCLUDED	X	X	X
DC37 and Teamster Local 858 Health Insurance	NOT INCLUDED	NOT INCLUDED	X	X
Additional Alzheimer's Disease Assistance Centers	NOT INCLUDED	NOT INCLUDED	X	X
Elder Health	NOT INCLUDED	NOT INCLUDED	X	X
<u>Office of Public Health</u>				
Suballocation to the Office of Children and Family Services for HIV Policy Development and Training	X	X	X	X
Suballocation to the State Education Department for AIDS Education in Elementary and Secondary Schools	X	X	X	X
Suballocation to the Division of Human rights for AIDS Discrimination Investigation	X	X	X	X
AIDS COLA	X	X	X	
Contracts with Community Services Programs	X	X	X	NOT INCLUDED
Multi-Service Agencies and Community Development	X	X	X	NOT INCLUDED
HIV, STD and Hepatitis C Prevention	X	X	X	X
HIV Health Care and Supportive Services	X	X	X	X
Hepatitis C	X	X	X	X
Additional Grants to Community Service Programs	X	X	X	X
Additional Grants to Existing Community Based Organizations	X	X	X	X
General Public Health Work	X	X	X	X
Public Health Emergency	X	X	X	X

Department of Health

Programs	State Budget Years			
	2012-2013	2013-2014	2014-2015	2015-2016
An "X" denotes the presence of the program in the State Budget for the year.				
Rabies Program	X	X	X	X
Family Planning Services	X	X	X	X
Additional Grants for Family Planning	X	X	X	X
Cystic Fibrosis Program	X	X	X	X
Early Intervention Program	X	X	X	X
Early Intervention Services for Family	X	X	X	X
Adolescent Pregnancy Prevention	X	X	X	X
Community Health Cost of Living Adjustment	X	X	X	X
Stockpile Storage for Vaccines and Supplies	X	X	X	X
Hypertension	X	X	X	X
Children's Asthma	X	X	X	X
School Based Health Centers	X	X	X	X
Additional School Based Health Centers	X	X	X	NOT INCLUDED
School Based Health Clinics (subject to schedule, 16 listed)	X	X	X	X
Migrant and Seasonal Farm Workers	X	X	X	X
Prenatal and Postpartum Home Visitation	X	X	X	X
Sexually Transmitted Disease Center of Excellence	X	X	X	X
Childhood Asthma Coalitions	X	X	X	X
Nutritional Services to Women, Infants and Children	X	X	X	X
Hunger Prevention and Nutritional Assistance	X	X	X	X
Sexuality-Related Programs	X	X	X	X
Rape Crisis Center	X	X	X	X
Evidence Based Cancer Services	X	X	X	X
Obesity and Diabetes Programs	X	X	X	X
Osteoporosis Prevention and Education	X	X	X	X
Public Health Leaders of Tomorrow	X	X	X	X
Racial Disparities	X	X	X	X

Department of Health

Programs	State Budget Years			
	2012-2013	2013-2014	2014-2015	2015-2016
An "X" denotes the presence of the program in the State Budget for the year.				
Statewide Health Broadcasts	X	X	X	X
Sudden Infant Death Syndrome	X	X	X	X
Tick-Borne Disease Institute	X	X	X	X
Comprehensive Care Centers for Eating Disorders	X	X	X	X
Safe Motherhood Initiatives	X	X	X	X
Minority Male Wellness	X	X	X	X
Latino Health Outreach	X	X	X	X
Health Promotion Initiatives	X	X	X	X
Statewide Maternal Mortality Reviews	X	X	X	X
Infertility Services	X	X	X	X
Additional Grants for Infertility Services	X	X	X	X
Adelphi University Breast Cancer Support	X	X	X	X
NYS Breast Cancer Network	X	X	X	X
Health Insurance Coverage for Home and Personal Care Workers	X	X	X	X
Grants to SUNY Hospitals at Stony Brook, Brooklyn and Syracuse	X	X	X	X
Public Education for Pain Management	X	X	X	X
Niagara Health Quality Coalition	X	X	X	X
Maternity and Early Childhood Foundation	X	X	X	X
Women's Health and Wellness Programs	X	X	X	NOT INCLUDED
Telehealth Demonstration Program	X	X	X	X
Nurse Family Partnership	X	X	X	X
Pluta Cancer Center	X	X	X	X
Pain Management	X	X	X	X
Water Supply Protection Program	X	X	X	X
Healthy Neighborhood Program	X	X	X	X
Genetic Services	X	X	X	X
Sickle Cell Screening	X	X	X	X
Tobacco Control and Cancer Services	X	X	X	X
Commodity Supplemental Food Program	X	X	X	X

Department of Health

Programs	State Budget Years			
	2012-2013	2013-2014	2014-2015	2015-2016
An "X" denotes the presence of the program in the State Budget for the year.				
Diabetes Research and Education	X	X	X	X
Tobacco Enforcement and Education	X	X	X	X
Autism Awareness and Research	X	X	X	X
Prostate and Testicular Cancer	X	X	X	X
Public Health Campaign TB	X	X	X	X
Indian Health Services	X	X	X	X
Physically Handicapped Children	X	X	X	X
School Health	X	X	X	X
Prenatal Care Assistance	X	X	X	X
Tobacco Enforcement	X	X	X	X
Evidence Based Cancer Services	X	X	X	X
Nutritional Services for Women, Infants and Children	X	X	X	X
Hypertension	X	X	X	X
Rape Crisis Centers	X	X	X	X
School Health Program	X	X	X	X
Maternity and Early Childhood Foundation	X	X	X	X
Tuberculosis Treatment, Detection and Prevention	X	X	X	X
Lead Poisoning Prevention	X	X	X	X
Lead Public Health Services	X	X	X	NOT INCLUDED
Drinking Water Program	X	X	X	X
Asbestos Safety Training	X	X	X	X
Occupational Health Clinics Account	X	X	X	X
Radon Detection Device	X	X	X	X
Regional/Targeted HIV, STD, Hep. C.	X	X	X	X
HIV, STED, Hep. C. Prevention	X	X	X	X
HIV Health Care/Supportive Services	X	X	X	X
HIV Clinical and Provider Education	X	X	X	X
Tobacco Use Prevention and Control Program	X	X	X	X
School Based Health Clinics	X	X	X	X
School Based Health Centers	X	X	X	X
Infertility	X	X	X	X

Department of Health

Programs	State Budget Years			
	2012-2013	2013-2014	2014-2015	2015-2016
An "X" denotes the presence of the program in the State Budget for the year.				
Family Planning	X	X	X	X
Childhood Lead Poisoning Primary Prevention	X	X	X	X
Childhood Obesity	X	X	X	X
Immunization Program	X	X	X	X
Regional Perinatal Centers	X	X	X	NOT INCLUDED
Family Planning Additional	NOT INCLUDED	X	NOT INCLUDED	X
Women's Special Health Network	NOT INCLUDED	X	NOT INCLUDED	NOT INCLUDED
School Based - Richfield Springs	NOT INCLUDED	X	NOT INCLUDED	NOT INCLUDED
Endometriosis Foundation	NOT INCLUDED	X	NOT INCLUDED	X
Eating Disorders Additional	NOT INCLUDED	X	NOT INCLUDED	NOT INCLUDED
Study on Broad Scale Systems Integration, Chautauqua County NYSARC	NOT INCLUDED	X	NOT INCLUDED	NOT INCLUDED
Finger Lakes Hlth Sys Agency	NOT INCLUDED	X	NOT INCLUDED	X
Health Insurance for home and personal care workers	NOT INCLUDED	X	NOT INCLUDED	X
Women's Health - Eating Disorders	NOT INCLUDED	X	NOT INCLUDED	NOT INCLUDED
Maternity & Early Childhood Foundation	NOT INCLUDED	X	NOT INCLUDED	X
New York State Breast Cancer Network	NOT INCLUDED	X	NOT INCLUDED	X
Early Intervention Additional	NOT INCLUDED	NOT INCLUDED	X	NOT INCLUDED
Rural Dentistry Pilot Program	NOT INCLUDED	NOT INCLUDED	X	X
Family Planning Additional	NOT INCLUDED	NOT INCLUDED	X	X

Department of Health

Programs	State Budget Years			
	2012-2013	2013-2014	2014-2015	2015-2016
An "X" denotes the presence of the program in the State Budget for the year.				
NYS Breast Cancer Network	NOT INCLUDED	NOT INCLUDED	X	X
NYS Coalition School Based Health	NOT INCLUDED	NOT INCLUDED	X	X
Women's Health Services	NOT INCLUDED	NOT INCLUDED	X	X
Maternity & Early Childhood Additional	NOT INCLUDED	NOT INCLUDED	X	X
Basset School Based Health Center	NOT INCLUDED	NOT INCLUDED	X	NOT INCLUDED
National Lymphatic Disease Patient Registry	NOT INCLUDED	NOT INCLUDED	X	X
21st Century Work Group on Disease Elimination	NOT INCLUDED	NOT INCLUDED	X	NOT INCLUDED
Eating Disorders Additional	NOT INCLUDED	NOT INCLUDED	X	NOT INCLUDED
Children's Environmental Centers	NOT INCLUDED	NOT INCLUDED	X	NOT INCLUDED
Pharmaceutical Take Back Program	NOT INCLUDED	NOT INCLUDED	X	NOT INCLUDED
Endometriosis Services	NOT INCLUDED	NOT INCLUDED	X	X
New Alternative for Children	NOT INCLUDED	NOT INCLUDED	X	NOT INCLUDED
Lyme Disease Task Force Recommendations	NOT INCLUDED	NOT INCLUDED	X	NOT INCLUDED
ComuniLife: Suicide Prevention of Latina Women	NOT INCLUDED	NOT INCLUDED	X	NOT INCLUDED
Cost of Living Adjustment Additional	NOT INCLUDED	NOT INCLUDED	X	NOT INCLUDED
Helen Hayes Hospital	NOT INCLUDED	NOT INCLUDED	X	X
NYC Veterans' Home	NOT INCLUDED	NOT INCLUDED	X	X

Department of Health

Programs	State Budget Years			
An "X" denotes the presence of the program in the State Budget for the year.	2012-2013	2013-2014	2014-2015	2015-2016
Oxford Veterans' Home	NOT INCLUDED	NOT INCLUDED	X	X
Batavia Veterans' Home	NOT INCLUDED	NOT INCLUDED	X	X
Montrose Veterans' Home	NOT INCLUDED	NOT INCLUDED	X	X

Department of State

Community Services Block Grant (CSBG) (funding available to providers in 2013-14, 2014-15 and 2015-16), including: CSBG Entitlement Grants; CSBG Workforce Development Grants; CSBG Workforce Development Grants for Targeted Areas; Office for New Americans Neighborhood-based Opportunity Center; CSBG Training and Technical Assistance Contracts; CSBG Disaster Relief.

Brownfields Opportunity Area (BOA) (funding available to providers in 2012-13, 2013-14, 2014-15)

Office of New Americans (ONA) (funding available in 2014-15 and 2015-16), including: ONA Statewide Legal Technical Assistance Request to Support Immigrant Service Providers in New York State (Legal Counsel and BIA Trainer); ONA Neighborhood-based Opportunity Center; Empire State Development, 2014-2015; Catholic Charities Hotline, 2014-2015, 2015-2016; NY Immigration Coalition, 2014-2015.

Legislative Member Items (funding available to providers in 2012-13, 2013-14, 2014-15 and 2015-16)

Public Utilities Law Project (funding available in 2012-13, 2013-14, 2014-15 and 2015-16)

NY Legislative Services Inc. (funding available in 2015-16)

African American Heritage Corridor (funding available in 2014-15)

Iron Mountain (funding available in 2014-15)

Division of Criminal Justice Services

New York State Prosecutors Training, including New York State Prosecutors Training Institute (NYPTI); New York State District Attorneys Association

Witness Protection Program

Re-entry Program, including Alternatives to Incarceration (ATI)

Operation IMPACT, including Anti-Gun Trafficking; IMPACT Tools; Crime Analysis Centers

Aid to Defense

New York State Defenders Association

Probation Classification Program (13-A)

Probation Demonstration Program, including Alternatives to Incarceration (ATI)

Probation Drug and Alcohol Program, including Alternatives to Incarceration (ATI)

Supervision and Treatment of Offenders (SATSO), including Alternatives to Incarceration (ATI)

200% Poverty Program (TANF), including Alternatives to Incarceration (ATI)

Probation Violation Residential Centers (PVRC), including Alternatives to Incarceration (ATI)

Legislative Member Items

Alternatives to Incarceration (ATI)

Indigent Legal Services, including Re-entry Prisoner Legal Services

Edward Byrne Memorial Grant Fund, including Enhanced Prosecution; Enhanced Defense; IMPACT Crime Analysis Centers; Video Interrogation Equipment; Firearm Backlog

Juvenile Justice Accountability Incentive Block Grant

Juvenile Justice and Delinquency Prevention Formula Program, including Juvenile Justice Formula Program (JJ); Juvenile Justice Title V Program (JT)

Violence Against Women Program

Civil and Domestic Violence Legal Services Program

Motor Vehicle Theft and Insurance Fraud Prevention Program

Probation Eligible Diversion Program, including Alternatives to Incarceration (ATI)

Center for Employment Opportunities

Miscellaneous Discretionary Account, including Second Chance Act; Sexual Assault Services

Homes and Community Renewal

Neighborhood Preservation Program

Rural Preservation Program

Office for the Aging

Community Services for the Elderly Program (CSE)

Expanded In-Home Services for the Elderly Program (EISEP)

Wellness in Nutrition (WIN) – formerly known as Supplemental Nutrition Assistance Program (SNAP). With the change in the Food Stamps Program to SNAP, the NYSOFA SNAP program name will change to Wellness in Nutrition effective with the 2013-14 State Budget.

NY Connects – Choices for Long Term Care.

Caregiver Resource Centers (CRC)

Long Term Care Ombudsman Program (LTCOP)

Respite

Social Adult Day Services (SADS)

Congregate Services Initiative (CSI)

Foster Grandparent Program (FGP)

Naturally Occurring Neighborhood Communities – Supportive Services Program (NORC-SSP or more simply NORC)

Neighborhood Naturally Occurring Neighborhood Communities (NNORC)

Retired and Senior Volunteer Program (RSVP)

Elderly Abuse Prevention

Transportation Operating Expenses

Patients' Rights and Advocacy Hotline

Health Insurance Information, Counseling and Assistance Program (HIICAP)

Managed Care Counseling and Assistance Program (MCCAP)

Community Empowerment

Enriched Social Adult Day Services

Title III-B – Supportive Services Program

Title III-C-1 – Congregate Meals

Title III-C-2 – Home Delivered Meals

Title III-D – Disease Prevention and Health Promotion Services Program

Title III-E – National Family Caregiver Support Program

Title VI – Ombudsman Program

Nutrition Services Incentive Program

Title V – Senior Community Services Employment Program

Senior Medicare Patrol Program (SMP)

Chronic Disease Self-Management Education (CDSME)

Systems Integration

Office for People with Developmental Disabilities

Assistive Supports

Assistive Technology Administration (Pilot)

Care At Home - III

Care at Home – IV & VI

Case Management (Non-Medicaid)

Certified Work Activity/Sheltered Workshop

Classroom Education

Community Residences – Supervised

Community Residences - Supportive

Consumer Transportation

Crisis Intervention

Day Training

Day Treatment – Freestanding

Day Treatment – Partial

Developmental Disabilities Program Council Grant

Epilepsy Services

Family Support Services

HCBS Adaptive Technologies

HCBS Community Habilitation Phase II (CH II)

HCBS Consolidated Supports and Services

HCBS Environmental Modifications

HCBS Family Education and Training

HCBS Freestanding Respite

HCBS Group Day Habilitation Service

HCBS Individual Day Habilitation Service (including Supplemental Individual Day Habilitation Service)

HCBS Intensive Behavioral Services (effective 10/1/2013)

HCBS Live-in Caregiver

HCBS Other Than Freestanding Respite

HCBS Pathways to Employment (effective 6/1/2014)

HCBS Prevocational Services

HCBS Residential Habilitation Family Care

HCBS Supervised IRA (Room and Board and Residential Habilitation Services)

HCBS Supplemental Group Day Habilitation Service

HCBS Supplemental Individual Day Habilitation Service

HCBS Supported Employment

HCBS Supportive IRA (Room and Board and Residential Habilitation Services)

HCBS Waiver Plan of Care Support Services

Home Care

ICF/DD (Over 30 Beds)

ICF/DD (30 Beds or Less)

Individualized Support Services

Information & Referral

Learning Institute (effective through 9/30/2014)

Medicaid Service Coordination

OPWDD Part 679 Clinic Treatment Facility (Article 16 Clinic)

OPWDD Part 679 Clinic Treatment Facility (Article 16 Clinic Joint Venture)

OPWDD Part 680 Specialty Hospital

Options for People Through Services (NYS OPTS)

People First Case Study (ended effective 7/1/2014)

Portal

Portal-like

Preschool Program

Program Development Grants and Start-Up (expires 6/30/2013)

Recreation and/or Fitness

Shelter Plus Care Housing

SOICF Sheltered Workshop/Day Training

Special Legislative Grant

Specialty Clinic

START Services (effective 1/1/2014)

Subcontract Services

Summer Camp

Supported Employment (Non-HCBS Waiver)

Transformation Opportunities (effective 7/1/2014)

Transitional Employment

Traumatic Brain Injury (TBI)

Voluntary Preservation Project (aka Voluntary Operated Maintenance Project - VAMM)

Willowbrook Case Services

Office of Alcoholism and Substance Abuse Services

Provider agencies operating one or more of the program services listed below may be considered in receipt of State Funds or State Authorized Payments if financial support for the program services came from:

1. a local county contract or a direct contract with OASAS for Aid to Localities funding (also known as state aid or net deficit funding), and/or
2. Medical Assistance revenue (Medicaid), and/or
3. Public Assistance revenue (Congregate Care).

Program Name	Service Type	Program Code
CRISIS		
Medically Supervised Withdrawal Services –	Crisis	3039
Medically Supervised Withdrawal Services – Outpatient	Crisis	3059
Medically Managed Detoxification	Crisis	3500
Medically Monitored Withdrawal	Crisis	3510
INPATIENT		
Chemical Dependence Inpatient Rehabilitation Services	Inpatient	3550
OPIOID TREATMENT		
Methadone-to-Abstinence – Outpatient	Opioid	0605
Methadone Maintenance – Residential	Opioid	2030
Methadone Maintenance – Outpatient	Opioid	2050
KEEP Units – Outpatient – Methadone	Opioid	2150
Methadone-to-Abstinence – Residential	Opioid	6030
OUTPATIENT		
Outpatient Chemical Dependence for Youth	Outpatient	0140
Compulsive Gambling Treatment	Outpatient	2780
Medically Supervised Outpatient	Outpatient	3520
Enhanced Medically Supervised Outpatient	Outpatient	3528
Outpatient Rehabilitation Services	Outpatient	3530
Specialized Services Substance Abuse Programs	Outpatient	4045
PREVENTION		
Compulsive Gambling Education, Assessment & Referral	Prevention	2790
Prevention Resource Centers	Prevention	3100
Primary Prevention Service	Prevention	5520
Other Prevention Services	Prevention	5550

Program Name	Service Type	Program Code
PROGRAM SUPPORT		
Support Services - Educational	Program	4074
Community Services	Program	4075
Resource	Program	4077
Program Administration	Program	4078
Legislative Member Item	Program	4778
RECOVERY		
Shelter Plus Care Housing	Recovery	3070
Shelter Plus Care Case Management	Recovery	3078
NY NY III: Post-Treatment Housing	Recovery	3270
NY NY III: Housing for Persons at Risk for Homelessness	Recovery	3370
Permanent Supported Housing	Recovery	3470
Permanent Supported Housing – High Frequency Medicaid	Recovery	3480
Recovery Community Centers	Recovery	3970
Recovery Community Organizing Initiative	Recovery	3980
RESIDENTIAL		
Residential Rehabilitation Services for Youth (RRSY)	Residential	3551
Intensive Residential	Residential	3560
Community Residential	Residential	3570
Supportive Living	Residential	3580
TREATMENT SUPPORT		
Job Placement Initiative	Treatment	0465
Case Management	Treatment	0810
Local Governmental Unit (LGU) Administration	Treatment	0890
Vocational Rehabilitation	Treatment	4072
Dual Diagnosis Coordinator	Treatment	5990

Office of Children and Family Services

Head Start Grant Program

Connections

Local Training Reimbursement

Discretionary Demo Account, including:

- Adoption Opportunities;
- Children's Justice Act;
- Community-Based Child Abuse Prevention;
- Family Violence Prevention;
- National Center on Child Abuse and Neglect;
- Project LAUNCH;
- State Early Childhood Comprehensive Systems

Youth Rehabilitation Account

Child Welfare

Social Services Block Grant

Youth Projects Account, including:

- Office of Juvenile Justice and Delinquency Prevention;
- National Institute of Justice;
- Department of Labor Workforce Investment Act (WIA)

Temporary Assistance for Needy Families

- TANF Advantage After School
- TANF-Settlement Houses
- TANF-Caretaker Relative
- TANF-Preventive Services
- TANF- Child Care and Development Fund (CCDF) NYC/Monroe Child Care /Demo
- TANF- Child Care and Development Fund (CCDF) Oneida/Capital Region Child Care

OCFS funded programs that are managed and dispersed by SUNY/CUNY:

- TANF- Child Care and Development Fund (CCDF) SUNY Subsidy & Quality
- TANF- Child Care and Development Fund (CCDF) CUNY Subsidy & Quality

OCFS funded programs that are managed and dispersed by OTDA:

- (TANF) Non-Residential Domestic Violence –
- TANF- Flexible Fund for Family Services (FFFS) to Title X

- TANF-FFFS to Community Optional Preventive Services (COPS)
- TANF-FFFS to Emergency Assistance for Families (EAF) Child Welfare
- TANF-FFFS to EAF Foster Care
- TANF-FFFS to EAF Foster Care Tuition
- TANF-FFFS to EAF Juvenile Detention (JD)/Person In Need of Supervision (PINS)
- TANF-FFFS to Non-Residential Domestic Violence (DV)
- TANF-FFFS to PINS Prevention/Detention/Dive

Commission for the Blind and Visually Handicapped (CBVH) Rehab Services/Basic Support

Foster Care Block Grant

Community Optional Preventive Services (COPS), including: COPS Base Funding; COPS \$1M Set-Aside Funding

Child Advocacy& Multidisciplinary Investing Teams

Committee on Special Education (CSE) Placements

Detention Capital

Secure & Non-Secure Detention

Supervision and Treatment Services for Juveniles Program

Runaway and Homeless Youth (RHYA)

Post Residential Services

Adult Protection / Domestic Violence Services – Statewide – 49% Reimbursement Possibly

Kinship Care Programs Healthy

Families Home Visits Advantage

After School Programs Close to

Home Juvenile Justice Community

Reinvestment

Public Private Partnership Primary Prevention Program

Youth Development and Delinquency Prevention Programs (YDDP)/Special Delinquency Prevention Program (SDPP)

Office of Mental Health (OMH)

A service provider that operates any of the OMH Programs Types listed below may be a covered provider.

Provider agencies operating one or more of the programs listed below may be considered in receipt of State Funds or State Authorized Payments if financial support for the program services came from:

1. A local county contract or a direct contract with OMH for State Aid/Aid to Localities/Net Deficit Funding (refer to the list of OMH funding source codes), and/or
2. Medicaid revenue, and/or
3. Medicaid Managed Care revenue, and/or
4. State Grant revenue, and/or
5. Funds passed through other non-governmental organizations.

Alphabetical List of OMH Program Codes

OMH Program Type	OMH Program Code
Adult Home Service Dollars	6920
Adult Home Supportive Case Management	6820
Advocacy/Support Services	1760
Affirmative Business/Industry	2340
Assertive Community Treatment (ACT) Program	0800
Assertive Community Treatment (ACT) Service Dollars	8810
Assisted Competitive Employment	1380
Blended Case Management	0820
Blended Case Management Service Dollars	0920
Case Management Service Dollars Administration	2810
Children and Youth Assertive Community Treatment	4800
Clinic Treatment	2100
Community Residence for Eating Disorder Integrated Treatment Program (CREDIT)	6110
Community Residence, Children & Youth	7050
Community Residence, Single Room Occupancy (SRO)	8050
Comprehensive PROS With Clinic	6340
Comprehensive PROS Without Clinic	7340
Conference of Mental Hygiene Directors	2860
Continuing Day Treatment	1310
Coordinated Children's Services Initiative	2990
CPEP Crisis Beds	2600
CPEP Crisis Intervention	3130
CPEP Crisis Outreach	1680
CPEP Extended Observation Beds	1920
Crisis Intervention	2680
Crisis Residence	0910

Alphabetical List of OMH Program Codes

OMH Program Type	OMH Program Code
Crisis/Respite Beds	1600
Day Treatment (Children & Adolescents)	0200
Drop In Centers	1770
Enclave in Industry	1340
Family Based Treatment Program	2040
Family Care	0040
Family Support Services (Children & Family)	1650
FEMA Crisis Counseling Assistance and Training	1690
Flexible Recipient Service Dollars (Non-Medicaid Programs)	1230
Geriatric Demo Gatekeeper	1410
Geriatric Demo Physical Health-Mental Health Integration	1420
HCBS Waiver	2300
Health Home Care Management	2730
Health Home Care Management Service Dollar Administration	2850
Health Home Care Management Service Dollars	2740
Health Home Non-Medicaid Care Management	2620
Home-Based Crisis Intervention	3040
Home-Based Family Treatment Model	1980
Homeless Placement Services	1960
Hospital for the Mentally Ill	2010
ICM Service Dollars	1910
Inpatient Psychiatric Unit of a General Hospital	3010
Intensive Case Management	1810
Intensive Psychiatric Rehabilitation Treatment (IPRT)	2320
Limited License PROS	8340
Local Governmental Unit (LGU) Administration	0890
Local Governmental Unit (LGU) Administration - Reinvestment and Medication Grant Program (MGP) – OMH Only	0860
MICA Network	5990
Monitoring and Evaluation, CSS	0870
Multicultural Initiative	3990
Non-Medicaid Care Coordination	2720
Ongoing Integrated Supported Employment Services	4340
On-Site Rehabilitation	0320
Outreach	0690
Partial Hospitalization	2200
Performance Based Early Recognition Coordination and Screening Services	1590
Permanent Housing Program (PHP)	1070
PROS Rehabilitation and Support Subcontract Services	9340
Psychosocial Club	0770
Recovery Center	2750
Recreation and/or Fitness	0610
Residential Treatment Facility – Children & Youth	1080
Residential Treatment Facility (RTF) Transition Coordinator	2880
Respite Services	0650
RTF/HCBS Service Dollars	2980

Alphabetical List of OMH Program Codes

OMH Program Type	OMH Program Code
School Based Mental Health	1510
SCM Service Dollars	6910
Self-Help Programs	2770
Shelter Plus Care Housing	3070
Sheltered Workshop/Satellite Sheltered Workshop	0340
Single Point of Access (SPOA)	1400
Special Legislative Grant	1190
Support Apartment	7080
Support Congregate	6080
Supported Education	5340
Supported Housing Community Services	6060
Supported Housing Rental Assistance	6050
Supported Single Room Occupancy (SP-SRO)	5070
Supportive Case Management (SCM)	6810
Teaching Family Home	4040
Transient Housing - THP, some PHP and some S+C (funds not flowing through OMH)	2070
Transition Management Services	1970
Transitional Business Model	6140
Transitional Employment Placement (TEP)	0380
Transportation	0670
Treatment Apartment	7070
Treatment Congregate	6070
Vocational and Educational Services – Children & Family (C & F)	1320
Work Program	3340

Office of Mental Health (OMH)

**Numeric List of OMH Funding Source Codes Related to
State Aid/Aid to Localities/Net Deficit Funding**

OMH Funding Source Code	OMH Funding Source Code Index	OMH Funding Source Description
001		Local Assistance - Regular State/Federal
001	A	Adults
014		Community Support Services
020		Direct Sheltered Workshop
021		Direct Local Assistance
031		Program Development Grants and Start-Up
031	B	Community Residence - Children
031	C	New York/New York
031	F	2000 Capital Bed Plan
031	G	New York/New York III PDG
034	J	Adult Case Management
034	K	Children and Family Case Management
036		Comprehensive Psychiatric Emergency Program
037		Ongoing Integrated Supported Employment Services
037	A	Peer Support/Psych. Rehab.
037	P	Personalized Recovery Oriented Services (PROS)
038	A	Legislative – New York State Psychiatric Association
038	B	Legislative – Medical Society of the State of New York
038	C	Legislative – National Association of Social Workers New York State Chapter –
038	E	Legislative – North Country Behavioral Healthcare Network
038	F	Legislative – Veteran Peer-to-Peer Pilot Programs
038	G	Legislative – Demo Program for Counties
039		Demonstration Grants
039	A	Legislative Special – Assembly Items
039	C	MICA
039	D	Legislative Special Contracts– Senate
039	G	Adult Family Support
039	I	Legislative - Member Items 001
039	J	Forensics
039	L	Psychiatric Rehabilitation
039	M	Support Services to Consumers
039	P	Clinical Infrastructure – Adult
039	Q	Innovative Psychiatric Rehab

**Numeric List of OMH Funding Source Codes Related to
State Aid/Aid to Localities/Net Deficit Funding**

OMH Funding Source Code	OMH Funding Source Code Index	OMH Funding Source Description
039	Z	Psychiatric Center Rent - Adult
041		Federal Community Mental Health Services Block Grant Funds
042		Federal Medicaid Infrastructure Grant
044		Federal Community Mental Health Services Block Grant Funds
046		Children and Families Program Grants
046	A	Clinical Infrastructure – Children and Families
046	C	Coordinated Children's Services Initiatives
046	G	C & F Emergency Services
046	L	C & F Community Support Programs
046	M	Mott Haven Community
046	N	Child & Family Clinic Plus (State Aid)
046	P	Child & Family Telepsychiatry (State Aid)
048	A	Homeless MI (PATH)
048	C	New York/New York (PATH)
049	B	Federal HUD Shelter Plus
062		Federal HUD Shelter Plus Care
072	A	Adult Community Residence Operating
072	B	Children CR Operating
072	C	Single Room Occupancy
072	D	RCCA Operating
072	E	NY/NY 2 Operating
072	F	2000 Capital Bed Plan – Operating
072	G	New York/New York III Operating
072	T	Community Residence Operating Costs for Former Transitional Care Individuals
073	A	Adult Community Residence Property
073	B	Children CR Property
073	C	New York/New York Property)
073	D	RCCA Property
073	E	NY/NY 2 Property
073	F	2000 Capital Bed Plan Property)
073	G	New York/New York III Property
073	T	Community Residence Property Costs for Former Transitional Care Individuals
074		Family Based Treatment
076		Residential Treatment Facilities
078		Independent Apartment/Supported Housing
078	A	Supported Housing Stipend Increase
078	G	New York/New York III Supported Housing
078	Z	Single Room Occupancy (SRO)
091	A	Federal SAMHSA (NYC Providers only)

**Numeric List of OMH Funding Source Codes Related to
State Aid/Aid to Localities/Net Deficit Funding**

OMH Funding Source Code	OMH Funding Source Code Index	OMH Funding Source Description
091	C	Federal Community Development Block Grant (Drop In Centers) (NYC Providers Only)
091	D	Federal HOPWA (NYC Providers only)
091	E	Emergency Shelter Grant (NYC Providers only)
091	E	Emergency Shelter Grant (NYC Providers only)
096	A	Community Based Family Care General -
096	K	Home and Community-Based Services Waiver - General
111		Federal Drug Free Schools & Communities Act
112		Outpatient State Aid
115		Residential – Adult Operating
115	D	Residential – Program Development
115	P	Residential – Adult Property
116		Residential – Children Operating
116	P	Residential – Children Property
119	A	Federal Forensic Initiatives
122		Community Support Programs - Misc
122	L	PROS Startup – Cash Advance
122	P	Prior Year Liability
122	U	PROS Start-Up Grants
122	W	Western Care Coordination Project – Reallocated Savings
130		Transitional Care
142	A	Expanded Community Support Adult
142	B	Expanded Community Support C&Y (Children & Youth)
162		Geriatric Health Act
164		Suicide Prevention
170	B	Kendra’s Assisted Outpatient (AOT) – Transitional Management (TM) –
170	C	Kendra’s Medication Grant Program (MGP) Administration
170	D	Kendra’s Medication Grant Program (MGP)
170	P	Kendra’s Proxy – Advance Directives
178		Adult Home Court Ordered
200		Community Reinvestment Services Fund
200	C	Supported Housing Workforce RIV
300		Homeless Mentally Ill Fund
400		Commissioner’s Performance Fund
503	A	COLA - 2002/2003 3 Percent PATH COLA
540		Co-Occurring Disorders
541		Managed Care Demonstration Programs
560	A	Behavioral Health Organization

**Numeric List of OMH Funding Source Codes Related to
State Aid/Aid to Localities/Net Deficit Funding**

OMH Funding Source Code	OMH Funding Source Code Index	OMH Funding Source Description
570		Health Home Care Management
580		Medicaid Redesign Team (MRT) Supported Housing Beds

Office of Temporary and Disability Assistance

Child Support, including: Child Well Being/Child Support Enforcement State General Funds; Child Well Being/Child Support Enforcement Federal Funds; Access and Visitation; Total Child Well Being/Child Support Enforcement

State General Funds, including: Disability Advocacy Program; Nutrition Outreach and Education Program; EBT/CBIC/AFIS; ESL/ABE; HIV; Career Pathways; Summer Youth Employment Program

TANF, including: EBT/AFIS; Access; Advantage Afterschool; ATTAIN, Bridge, Career Pathways; Caretaker Relative; Centro Oneida; Community Solutions for Transportation; CUNY/Daycare; Childcare Pilot - NYC - Monroe County; Childcare Pilot - Capital Region – Oneida; SUNY childcare; Disability Advocacy Program; Displaced Homemakers Program; Educational Resource; Emergency Needs Homeless Program; Fatherhood; Non Res DV; Preventive service; New York State Refugee Resettlement Assistance Program; RGRTA; Settlement House; SHFYA; SHIP; Child care subsidies; Flexible Fund for Family Services; Nurse Family Partnership; Food Pantries; Wage Subsidy Program; Wheels for Work

Federal Supplemental Nutrition Assistance Program, including: SNAP Employment & Training; SNAP Administration; SNAP Employment & Training Venture Program; SNAP Outreach <1; SNAP Nutrition Education

Federal Refugee Program, including; Refugee Cash and Medical Assistance; Cuban-Haitian Program; Refugee Social Services Program; Targeted Assistance Grant Program; Refugee School Impact Program; Services to Older Refugees; Making a Connection

Refugee Program – State General Fund, including: Citizenship; New York State Refugee Resettlement Assistance; Human Trafficking

Homeless Housing – State General Fund, including: Adult shelters; Homeless programs (NYSSHP/STEHP/OSAH); New York State Supportive Housing Program; Solutions to End Homelessness Program; Operational Support for AIDS Housing; Homeless programs (STEHP additional); Homeless programs (NYSSHP additional); Homeless Supplement NYC; Niagara Community Action Program; Carolyn House YMCA; NY/NY III

Homeless Housing Account Fed 290, including Emergency Solutions Grant Program; Housing Opportunities for Persons with AIDS; Homeless ARRA

Family and Adult Shelter Sanction Acct (339)

Homeless Housing Grants Program

Office of Victim Services

Crime Victim Legal assistance Account

CVB – Conference Fee Account

Federal Victim Assistance Funds

Federal Victim Compensation Funds

New York State Criminal Justice Improvement Account

Restitution funds

Appendix C.

Recognized Cost Reports

AG & MKTS

- No annual Cost Reports for EO #38 purposes

DCJS

- No annual Cost Reports for EO #38 purposes

DOCCS

- No annual Cost Reports for EO #38 purposes

DOH

- Institutional Cost Report (ICR)
- Ambulatory Health Care Facility (AHCF) cost report
- Residential Health Care Facility Report (RHCF-4)
- Residential Health Care Facility Report (RHCF-2)
- Personal Care Cost Report
- Certified Home Health Agency Cost Report
- Long Term Home Health Agency Cost Report
- Program specific Annual Medicaid Managed Care Operating Reports (MMCOR) (MMCOR, HIV-SNP, Medicaid Advantage, MLTC, PACE MLTC, and Partial Cap MLTC)
- Annual financial reports submitted to the NYS Division of Financial Services (DFS) and DOH using the National Association of Insurance Commissioners (NAIC) and New York Data Requirement formats
- Consolidated fiscal reports required under section 10 NYCRR 69-4.5(2)

DOS

- No annual Cost Reports for EO #38 purposes

HCR

- Neighborhood and Rural Preservation Companies Annual Performance Report

NYSOFA

- No annual Cost Reports for EO #38 purposes

OASAS

- Consolidated Fiscal Report (CFR)

OCFS

- Statewide Standards of Payment Reports

OMH

- Consolidated Fiscal Report (CFR)
- Institutional Cost Report (ICR)
- DMH Supplements to the Institutional Cost Report

OPWDD

- Consolidated Fiscal Report (CFR)

OTDA

- No annual Cost Reports for EO #38 purposes

OVS

- Fiscal Cost Report

