NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2015 to December 31, 2015

SCHEDULE CFR-i
AGENCY IDENTIFICATION AND CERTIFICATION STATEMENT

AGENCY NAME: _____
AGENCY ADDRESS: _____
_____

☐ Please check the box if the agency address changed from the prior reporting period.

AGENCY CODE: _____
COUNTY NAME: _____
COUNTY CODE: _____

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

SCHOOL CODE (SED ONLY): __ __ __ __ __ __ __ __ __ __ __ __

FEDERAL EMPLOYER ID NUMBER: _____

Person to Contact with Regard to Questions Concerning this Report:

_____ ( ) _____
Name Telephone Number

_____
Title

_____ ( ) _____
E-mail Address FAX Number

☐ Please check the box if the person to contact changed from the prior reporting period.

CERTIFIED FINANCIAL STATEMENT REPORTING PERIOD: _____

CHECK THE STATE AGENCY(IES):
☐ OMH
☐ OPWDD
☐ OASAS
☐ SED

CHECK THE CFR SUBMISSION TYPE:
☐ FULL CFR
☐ ABBREVIATED CFR
☐ ARTICLE 28 ABBREVIATED CFR
☐ MINI-ABBREVIATED CFR
☐ ESTIMATED CLAIM

MISREPRESENTATION OF ANY INFORMATION CONTAINED IN THIS REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER NEW YORK STATE LAW.

CERTIFICATION STATEMENT

I HEREBY CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT, THAT THE INFORMATION FURNISHED IN THIS REPORT HAS BEEN COMPLETED IN ITS ENTIRETY, AND IS IN ACCORDANCE WITH THE INSTRUCTIONS AND IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER ATTEST TO THE FACT THAT THERE ARE RECORDS AND ALLOCATION WORKSHEETS TO SUPPORT ALL THE INFORMATION CONTAINED HEREIN, IN THE CUSTODY OF THE ABOVE NAMED SPONSORING AGENCY. I ACKNOWLEDGE THAT THE DEPARTMENT OF MENTAL HYGIENE, OR ANY OF ITS OFFICES OR DIVISIONS, OR THE STATE EDUCATION DEPARTMENT, OR ANY OF ITS OFFICES OR DIVISIONS, MAY REJECT THIS REPORT IF IT HAS NOT BEEN FULLY, OR ACCURATELY COMPLETED.

_____
Date

_____
Name and Title

_____
E-mail Address

( ) _____
Telephone Number

_____
Signature of Chief Executive Officer

☐ Please check the box if the Chief Executive Officer changed from the prior reporting period.

COMPLETE ONLY IF THIS REPORT CONTAINS STATE AID FUNDED PROGRAMS

NEW YORK STATE
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For the Period: January 1, 2015 to December 31, 2015

SCHEDULE CFR-iii COUNTY/NYC CERTIFICATION STATEMENT

AGENCY NAME: _____ **AGENCY CODE:** _____ **Page____**

COUNTY/NYC - OPERATED OR VOLUNTARY LOCAL SERVICE PROVIDER CERTIFICATION

I certify that the attached statement fully and accurately represents all reportable income and expenditures made for services performed in accordance with the provision of the Mental Hygiene Law and approved budgets.

There are records and worksheets to support this statement in the custody of the above named agency. Such records and worksheets include the necessary summaries of payrolls and time records, abstracts from ledgers, registers or other expense records. All income from fees, all payments by other State or Federal agencies and any other income have been recorded, included and summarized in support of the amounts reported herein.

Records and worksheets, including records which show that the agency has applied for and received, or received formal notification of refusal of, all forms of third party reimbursement and federal aid, which may be appropriate for such services, are on file at the above location and available for audit by the Office of the State Comptroller and/or representatives of the New York State Commissioner of the Office of Alcoholism and Substance Abuse Services, Commissioner of the Office For People With Developmental Disabilities, or the Commissioner of the Office of Mental Health.

I understand that the State Aid paid on the basis of this certification for local assistance providers may be adjusted, modified and reduced if the records referred to above do not support this financial statement, and that such a reduction may require a repayment to the State of any overpayments which are disclosed by audit.

Signed: _____
(For Voluntary Local Service Provider)

Title: _____
(Service Provider's Chief Executive Officer)

Date: _____

Signed: _____
(For County/City Operated Local Service Provider)

Title: _____
(LGU's Chief Fiscal Officer)

Date: _____

LOCAL GOVERNMENTAL UNIT CERTIFICATION

I have verified that the costs and revenue reported in the Total column of Schedule DMH-3 are consistent with the contract expenditures and income amounts as approved by this local governmental unit. I also affirm that the expenditures were necessary to provide the services covered by the approved budget and that further review will establish if all income has been fully reported.

I understand that the State Aid paid to this local governmental unit on the basis of this certification may be adjusted, modified and reduced if records are not available, or do not support this financial statement. I hereby recommend that final reimbursement be approved.

Signed: _____
Director of Community Mental Health Services

Local Governmental Unit: _____
Specify

Date: _____

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2015 to December 31, 2015

SCHEDULE CFR-2
AGENCY FISCAL SUMMARY

AGENCY NAME:_____	**THE RECONCILIATION SCHEDULE MUST BE COMPLETED WHEN:**
AGENCY CODE:_____	(1) the expenses and revenues in the CFR do not equal the expenses and revenues in the audited financial statements and
SCHOOL CODE: (SED ONLY) __ __ __ __ __ __ __ __ __ __ __ __	(2) the reporting periods of the CFR and financial statements coincide.

Line No.	COLUMN NUMBER / ITEM DESCRIPTION / EXPENSES		Cost Codes	1 AGENCY TOTALS (Sum Col. 2-7)	2 OASAS TOTALS	3 OMH TOTALS	4 OPWDD TOTALS	5 SED TOTALS	6 SHARED PROGRAM TOTALS	7 OTHER PROGRAMS TOTALS*
1	Personal Services	(CFR-1, Line 16)	31999							
2	Vacation Leave Accruals	(CFR-1, Line 17)	32999							
3	Fringe Benefits	(CFR-1, Line 20)	33999							
4	OTPS	(CFR-1, Line 41)	34999							
5	Equipment-Provider Paid	(CFR-1, Line 48)	35999							
6	Property-Provider Paid	(CFR-1, Line 63)	36999							
7	Net Agency Admin.	(CFR-1, Line 65)	38050							
8	Adj./Non-Allow. Costs	(CFR-1, Line 66)	38030							
9	Total Adj. Expenses	(Sum Lines 1-7 minus 8)	38999							
	REVENUES									
10	Gross Revenues	(CFR-1, Line 95)	40999							
11	GAAP Adj. to Revenue	(CFR-1, Line 99)	43999							
12	Net GAAP Revenues	(Line 10 minus Line 11)	44999							

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

Funding State Agency:
☐ OMH ☐ SED
☐ OPWDD
☐ OASAS

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2015 to December 31, 2015

SCHEDULE CFR-4
PERSONAL SERVICES

AGENCY NAME:_____
AGENCY CODE:_____
SCHOOL CODE: (SED ONLY) __ __ __ __ __ __ __ __ __ __ __ __

FTE'S MUST BE CALCULATED TO 3 DECIMAL PLACES.

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

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

	COLUMN NUMBER																			
	PROGRAM CODE ** (PROGRAM CODE INDEX)					( )			( )			( )			( )			( )		
	PROGRAM/SITE IDENTIFICATION NUMBER **																			
	PROGRAM/SITE NAME																			
Position	**PROGRAM/SITE ADDRESS (Line One)**																			
Title Code	**PROGRAM/SITE ADDRESS (Line Two)**																			
Appendix	**COUNTY CODE**																			
R	**Position Title**	**Standard Work Week**				**Hours Paid**	**FTE**	**Amount Paid**	**Hours Paid**	**FTE**	**Amount Paid**	**Hours Paid**	**FTE**	**Amount Paid**	**Hours Paid**	**FTE**	**Amount Paid**	**Hours Paid**	**FTE**	**Amount Paid**
		35	**37.5**	**40**	**Other**															
Total "Hours Paid", "FTE" and "Amount Paid" for Positions.																				

* **Report Agency Administration in one column on a separate page.**
** **For OASAS, program code = service level and program/site = PRU level.**
Totals are transferred to Schedule CFR-1 Line 16 (Program/Site, Program Administration & LGU Administration), or Schedule CFR-3 Line 1 (Agency Administration).
Note: FTE's do not get transferred.

Funding State Agency:
☐ OMH ☐ SED
☐ OPWDD
☐ OASAS

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
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SCHEDULE CFR-4A
CONTRACTED DIRECT CARE AND CLINICAL PERSONAL SERVICES

AGENCY NAME:_____
AGENCY CODE:_____
SCHOOL CODE: (SED ONLY) __ __ __ __ __ __ __ __ __ __ __ __ __

Refer to Appendix R for Position Title Codes and definitions.
Report only program/site specific positions (Position Title Codes 200-399 series).

Position Title Code Appendix R											
	COLUMN NUMBER										
	PROGRAM CODE (PROGRAM CODE INDEX)		( )		( )		( )		( )		( )
	PROGRAM/SITE IDENTIFICATION NUMBER										
	PROGRAM/SITE NAME										
	PROGRAM/SITE ADDRESS (Line One)										
	PROGRAM/SITE ADDRESS (Line Two)										
	COUNTY CODE										
	Position Title	**Hours Paid**	**Amount Paid**	**Hours Paid**	**Amount Paid**	**Hours Paid**	**Amount Paid**	**Hours Paid**	**Amount Paid**	**Hours Paid**	**Amount Paid**
Total "Hours Paid" and "Amount Paid" for Positions.											

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

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2015 to December 31, 2015

SCHEDULE CFR-5
TRANSACTIONS WITH RELATED ORGANIZATIONS/INDIVIDUALS

AGENCY NAME:_____ **AGENCY CODE:** _____ **SCHOOL CODE: (SED ONLY)** __ __ __ __ __ __ __ __ __ __ __ __

SECTION A: ***NOTE: (OASAS and OPWDD providers only): For purposes of this schedule, "related organizations and/or individuals" shall include closely allied entities as described and defined in Article 25.06 of Mental Hygiene Law and on page 18.2 of the CFR Manual. OASAS providers are also directed to refer to Local Services Bulletin 1999-02.***

Question #1: **During the reporting period, were there any PAYMENTS TO related organizations or individuals associated with the provider that involved any OASAS, OMH, OPWDD and/or SED programs and/or agency administration? YES _____ NO _____ If yes, Sections B and C of this schedule must be completed.**

Question #2: **(Applies only to OASAS and OPWDD service providers) During the reporting period, were there any transactions with related organizations or individuals FROM WHICH the service provider received any financial aid/assistance or TO WHICH the service provider provided financial aid/assistance? YES ___ NO ___ If yes, Section D must be completed.**

SECTION B: **Please list all PAYMENTS TO related organizations and/or individuals below:**

1	2	3	4	5	6	7	8	9
Line No.	Item No.	PROGRAM/SITES AFFECTED ENTER PROG/SITE ID# (CODE) OR ADMINISTRATION	DESCRIPTION OF TRANSACTION	NAME OF RELATED ORGANIZATION/INDIVIDUAL	RELATIONSHIP TO PROVIDER*	AMOUNT OF TRANSACTION REPORTED	ALLOWABLE COSTS	ADJUSTMENTS TO COSTS (COL. 7 MINUS 8)
1								
2								
3								
4								
5								

SECTION C: **For space lease/rental agreements listed in section B above, detail the related organization's/individual's allowable costs reported in section B, col. 8 above:**

1	2	3	4	5	6	7	8	9
Line No.	Item No.	PROGRAM/SITES AFFECTED ENTER PROG/SITE ID# (CODE) OR ADMIN.	DEPRECIATION	MORTGAGE INTEREST	INSURANCE	PROPERTY TAXES	OTHER (SPECIFY)	TOTAL ALLOWABLE COSTS
1								
2								
3								
4								
5								

SECTION D: **(This section applies only to OASAS and OPWDD service providers.) Report each related party/related individual FROM WHICH the service provider received any financial aid or assistance or TO WHICH the service provider provided any financial aid or assistance.**

1	2	3	4	5	6	7		8
						Funding		Funding To/From
Line #	Item #	Name of Related Party/Individual	Street Address	City, State	Type of Financial Support/Aid	To	From	Amount
1						☐	☐	
2						☐	☐	
3						☐	☐	
4						☐	☐	
5						☐	☐	

*** See Section 18.0 of the CFR Manual for the relationship key.**

Funding State Agency:
☐ OMH
☐ OPWDD
☐ OASAS

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2015 to December 31, 2015

SCHEDULE DMH-2
AID TO LOCALITIES/
DIRECT CONTRACT
SUMMARY

AGENCY NAME:_____ PREPARED BY: _____ TELEPHONE: (___) _____

AGENCY CODE:_____ ☐ Please check the box if the preparer changed from the previous submission.

COUNTY NAME & CODE: _____(___) PLEASE CHECK: ESTIMATED CLAIM ____ FINAL CLAIM _____

Line No.	COLUMN NUMBER / ITEM DESCRIPTION	Cost Codes					
1	Accounting Method						
2	State Contract Number / LGU Contract Number *	00200					
3	Program Type	00072					
4	Program Code (Program Code Index)	00012	( )	( )	( )	( )	( )
	EXPENSES						
5	Personal Services	18010					
6	Vacation Leave Accruals **	18020					
7	Fringe Benefits	18030					
8	Other Than Personal Services (OTPS)	18040					
9	Equipment-Provider Paid ***	18050					
10	Property-Provider Paid ****	18060					
11	Agency Administration	18080					
12	Adjustments/Non-Allowable Costs (Detail Required)	18090					
13	Total Adjusted Expenses (Lines 5-11 minus 12)	18999					
	REVENUES						
14	Participant Fees (less SSI & SSA)	46010					
15	SSI & SSA	46020					
16	Home Relief/Public Assistance	46030					
17	Medicaid	46040					
18	Medicare	46060					
19	Other Third Parties	46070					
20	OPWDD Residential Room and Board/NYS OPTS	46080					
21	Transportation, Medicaid	46090					
22	Transportation, Other	46100					
23	Sales: Contract Total	46140					
24	Federal Grants (Detail Required)	46160					

* For direct contracts, enter the State Contract Number. For local contracts, enter the local Contract Number, if applicable.
** OASAS funded service providers cannot report vacation leave accruals for State aid reimbursement.
*** OASAS funded service providers cannot report equipment depreciation for State aid reimbursement.
**** OASAS funded service providers cannot report property related depreciation for State aid reimbursement.

Funding State Agency:
☐ OMH
☐ OPWDD
☐ OASAS

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2015 to December 31, 2015

SCHEDULE DMH-2
AID TO LOCALITIES/
DIRECT CONTRACT
SUMMARY

AGENCY NAME:_____ PREPARED BY: _____ TELEPHONE: (___) _____

AGENCY CODE:_____ ☐ Please check the box if the preparer changed from the previous submission.

COUNTY NAME & CODE: _____(___) PLEASE CHECK: ESTIMATED CLAIM ____ FINAL CLAIM _____

Line No.	COLUMN NUMBER / ITEM DESCRIPTION	Cost Codes					
	Program Type	00072					
	Program Code (Program Code Index)	00012	( )	( )	( )	( )	( )
25	State Grants (Detail Required)	46190					
26	LTSE Income Total (OMH and OPWDD Only)	46220					
27	SNAP (OASAS and OPWDD Only)	46240					
28	Net Deficit Funding (State & LGU Funding Only)*	46110					
29	Other (Detail Required)	46230					
30	Total Gross Revenue (Sum Lines 14-29)	46999					
	GAAP ADJUSTMENTS TO REVENUE						
31	Participant Allowance	47010					
32	Uncollectible Accounts Receivable	47040					
33	Other (Detail Required)	47045					
34	Total GAAP Adjustments (Sum Lines 31-33)	47049					
35	Net GAAP Revenues (Line 30 minus 34)	47025					
	NON-GAAP ADJUSTMENTS TO REVENUE						
36	Exempt Contract Income	47050					
37	Exempt LTSE Income	47060					
38	Net Deficit Funding**	47070					
39	Other (Detail Required)	47080					
40	Total NON-GAAP Adjustments (Sum Lines 36-39)	47998					
41	Subtotal Adj. to Revenue (Sum Lines 34 & 40)	47999					
42	Total Net Revenues (Line 30 minus 41)	48999					
43	Net Operating Costs (Line 13 minus 42)	49999					
	DEFICIT FUNDING						
44	State Share	60010					
45	Local Government Share	60020					
46	Service Provider Share (Voluntary Contributions)	60030					
47	Total Approved Deficit Funding (Sum lines 44 - 46)	60039					
48	Non-Funded	60040					
49	Total Net Deficit (Sum Lines 47-48)	60999					

* Do not include non-funded or voluntary contributions.
** Amounts should equal the corresponding amounts reported as revenue on line 28 above.

FundingState Agency:
☐ OMH
☐ OPWDD
☐ OASAS

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2015 to December 31, 2015

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

AGENCY NAME:_____ PREPARED BY: _____ TELEPHONE: (___) _____

AGENCY CODE:_____ ☐ Please check the box if the preparer changed from the previous submission.

COUNTY NAME & CODE: _____(____) PLEASE CHECK: ESTIMATED CLAIM ____ FINAL CLAIM _____

Line No.	COLUMN NUMBER / ITEM DESCRIPTION	Cost Codes						TOTAL
1	Accounting Method							
2	Program Type	00073						
3	Program Code (Program Code Index)	00013	( )	( )	( )	( )	( )	
4	Total Persons Served/Month	00220						
5	Total Units of Service	00999						
6	Gross Cost/Unit of Service	70999						
7	Net Cost/Unit of Service	71999						
8	Please Check If Participant Specific Methodology Is Used (OPWDD ONLY)	72999						
9	A. Funding Source Code (Local Assistance) Index (OMH/OASAS only)		001	001	001	001	001	
10	Number Persons Served/Month	00260						
11	Number Units of Service	00250						
12	Total Adjusted Expenses	50999						
13	Less Applied Net Revenue	61999						
14	Net Operating Costs	62999						
15	State Contract Number / LGU Contract Number *	00201						
16	B. Funding Source Code Index (OMH/OASAS only)							
17	Number Persons Served/Month	00261						
18	Number Units of Service	00251						
19	Total Adjusted Expenses	50998						
20	Less Applied Net Revenue	61998						
21	Net Operating Costs	62998						
22	State Contract Number / LGU Contract Number *	00202						
23	C. Funding Source Code Index (OMH/OASAS only)							
24	Number Persons Served/Month	00262						
25	Number Units of Service	00252						
26	Total Adjusted Expenses	50997						
27	Less Applied Net Revenue	61997						
28	Net Operating Costs	62997						
29	State Contract Number / LGU Contract Number *	00203						
	D. Totals From A-C Above							
30	Total Adjusted Expenses	51999						
31	Less Net Revenue	63999						
32	Net Operating Costs	52999						

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