NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: July 1, 2014 to June 30, 2015

SCHEDULE CFR-i
AGENCY IDENTIFICATION AND CERTIFICATION STATEMENT

Page____

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 ______________________

( ) Telephone Number ______________________

E-mail Address ______________________

Signature of Chief Executive Officer ______________________

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

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2014 to June 30, 2015

SCHEDULE CFR-3
AGENCY ADMINISTRATION

Page _____

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

Line No.	ITEM DESCRIPTION	COST CODES	AGENCY ADMIN TOTALS
	PERSONAL SERVICES		
1	Total Personal Services (from CFR-4, Agency Admin.)	11998	
2	Vacation Leave Accruals	12998	
	FRINGE BENEFITS		
3	Mandated Fringe Benefits	13201	
4	Non-Mandated Fringe Benefits	13301	
5	Total Fringe Benefits (Sum Lines 3 - 4)	13998	
	OTHER THAN PERSONAL SERVICES (OTPS)		
6	Audit/Legal	14200	
7	Utilities	14210	
8	Telephone	14220	
9	Repairs and Maintenance	14021	
10	Office Supplies and Postage	14161	
11	Organizational Expense	14230	
12	Interest - Working Capital	14240	
13	Expensed Equipment	14081	
14	Contracted Personal Services	14151	
15	Staff Travel	14251	
16	Insurance - General	14261	
17	Other (Detail Required)	14997	
18	Total OTPS (Sum Lines 6 - 17)	14996	
	EQUIPMENT-PROVIDER PAID		
19	Lease/Rental-Vehicle	15011	
20	Lease/Rental-Equipment	15030	

Line No.	ITEM DESCRIPTION	COST CODES	AGENCY ADMIN TOTALS
	EQUIPMENT-PROVIDER PAID (CONTINUED)		
21	Depreciation-Vehicle	15041	
22	Depreciation-Equipment	15060	
23	Interest-Vehicle	15071	
24	Other (Detail Required)	15997	
25	Total Equipment (Sum Lines 19 - 24)	15996	
	PROPERTY-PROVIDER PAID		
26	Lease/Rental-Real Property	16011	
27	Leasehold/Leasehold Improvements	16021	
28	Depreciation-Building	16031	
29	Depreciation-Building/Land Improvements	16050	
30	Mortgage Interest	16061	
31	Mortgage Expenses	16071	
32	Insurance-Property & Casualty	16081	
33	Real Estate Taxes	16091	
34	Maintenance in Lieu of Rent (LGU only)	16141	
35	Interest on Capital Indebtedness	16101	
36	Other (Detail Required)	16997	
37	Total Property (Sum Lines 26 - 36)	16996	
38	Parent Agency Administration Allocation	19070	
39	County Wide Cost Allocation (LGU Only)	19080	
40	Total Agency Administration (Sum Lines 1,2,5,18,25,37,38,39)	19090	
41	Adjustments/Non-Allowable Costs (Detail Required)	19031	
42	Net Agency Administration (Line 40 minus 41)	19998	

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For the Period: July 1, 2014 to June 30, 2015

SCHEDULE CFR-3
AGENCY
ADMINISTRATION

Page _____

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

RATIO VALUE WORKSHEET (AGENCY-WIDE)

Line No.	State Agency	Cost Codes	Amount
	CALCULATION OF OPERATING COSTS *		
43	OASAS Subtotal	19110	
44	OMH Subtotal	19120	
45	OPWDD Subtotal	19130	
46	SED Subtotal	19140	
47	Shared Programs Subtotal	19150	
48	Other Programs Subtotal**	19160	
49	Total Agency Operating Costs	19170	
	CALCULATION OF RATIO VALUE FACTOR		
50	Net Agency Administration (CFR-3, Line 42)	19999	
51	Total Agency Operating Costs (CFR-3, Line 49)	19171	
52	Ratio Value Factor (Line 50 divided by line 51)	19180	
	ALLOCATION OF AGENCY ADMINISTRATION USING RATIO VALUE ***		
53	OASAS Allocation (line 43 x line 52)	19210	
54	OMH Allocation (line 44 x line 52)	19220	
55	OPWDD Allocation (line 45 x line 52)	19230	
56	SED Allocation (line 46 x line 52)	19240	
57	Shared Programs Allocation (line 47 x line 52)	19250	
58	Other Programs Allocation (line 48 x line 52)	19260	
59	Total Agency Administration (sum lines 53 - 58)	19270	

ADJUSTED RATIO VALUE WORKSHEET (WITHIN STATE AGENCY)

Line No.	State Agency	Cost Codes	Amount
	CALCULATION OF ADJUSTED OPERATING COSTS *****		
60	OASAS Adjusted Subtotal	19310	
61	OMH Adjusted Subtotal	19320	
62	OPWDD Adjusted Subtotal	19330	
63	SED Adjusted Subtotal	19340	
64	Shared Programs Adjusted Subtotal	19350	
	CALCULATION OF ADJUSTED RATIO VALUE FACTOR *******		
65	OASAS Ratio Value Factor (line 53 divided by line 60)	19410	
66	OMH Ratio Value Factor (line 54 divided by line 61)	19420	
67	OPWDD Ratio Value Factor (line 55 divided by line 62)	19430	
68	SED Ratio Value Factor (line 56 divided by line 63)	19440	
69	Shared Programs Ratio Value Factor (line 57 divided by line 64)	19450	

* Totals by State Agency from CFR-1, Line 64. Do not report operating costs for programs 0880 and 0890.
** This amount must equal the sum of lines 1 through 4 of column 7 on schedule CFR-2. These amounts are not detailed elsewhere in the CFR and, therefore, will not cross foot to CFR-1.
*** For each state agency, the sum of agency administration allocated to each program/site on CFR-1, line 65, must equal the agency administration calculated below.
**** Totals by State Agency from CFR-1, Line 64. Do not report operating costs for programs 0880 and 0890 and programs which are exempt from agency administration.
For OMH (line 61) , do not include operating costs for programs 0860, 0870, 0920, 1230, 1690, 1910, 2740, 2850, 2860, 2980, 6910, 6920, 8810 and programs with an "A" program code index (startup).
For OPWDD Specific (line 62), do not include operating costs for program 7091.
***** The adjusted ratio value factor for each State Agency should appear in the item description column of that State Agency specific CFR-1, line 65.

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

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: July 1, 2014 to June 30, 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) ____***

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	**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.

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CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2014 to June 30, 2015

SCHEDULE CFR-6
GOVERNING BOARD AND
COMPENSATION SUMMARY

Page ____

AGENCY NAME: ______________________ AGENCY CODE: __________ SCHOOL CODE (SED ONLY): __ __ __ __ __ __ __ __ __ __ __ __

1. Do any employees of your agency also serve on the governing authority? ___ YES ___ NO If "YES", provide detail of the employee name and position title.
2. List the names of all individuals who receive compensation as Board Officers, Members of the Board of Directors or Board Trustees:

	NAME	AMOUNT PAID	CONTRACTED PAYMENT AMOUNT	FRINGE BENEFITS	OTHER BENEFITS **	TOTAL COMPENSATION
A.						
B.						
C.						
D.						
E.						

3. List ALL employees whose total annualized salary and contracted payment (column 7) is in excess of $125,000 per year.

AND

The five highest paid employees whose total annualized salary and contracted payment amount (column 7) is in excess of $75,000 per year.

	(1) NAME	(2) POSITION TITLE CODE *	(3) AMOUNT PAID	(4) FTE	(5) ANNUALIZED SALARY	(6) CONTRACTED PAYMENT AMOUNT	(7) TOTAL ANNUALIZED SALARY AND CONTRACTED PAYMENT	(8) FRINGE BENEFITS	(9) OTHER BENEFITS **
A.		☐							
B.		☐							
C.		☐							
D.		☐							
E.		☐							

4. List the five highest paid independent contractors (individual or firm) that received payments in excess of $50,000.

	(1) NAME	(2) TYPE OF SERVICE	(3) AMOUNT PAID
A.			
B.			
C.			
D.			
E.			

5. Number of additional employees whose annualized salary and/or contracted payment amount is in excess of $75,000. ____________

* If an individual is reported under more than one position title code on CFR-4, please check the box in column 2.

** Cash value of awards, rewards, loans or other benefits made in lieu of, or in addition to, monetary compensation or regular fringe benefits.
Regular fringe benefits are received by all classes or categories of employees. (e.g.: Payroll Taxes, Health Insurance, Pension Contributions, and Tuition Reimbursement)

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

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2014 to June 30, 2015

SCHEDULE DMH-2
AID TO LOCALITIES/ DIRECT CONTRACT SUMMARY

Page _____

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: July 1, 2014 to June 30, 2015

SCHEDULE DMH-2
AID TO LOCALITIES/
DIRECT CONTRACT
SUMMARY

Page _____

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: July 1, 2014 to June 30, 2015

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

Page _____

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.