

Please Check State Agency:

- OMH
- OMRDD
- OASAS

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: July 1, 2006 to June 30, 2007*

**SCHEDULE DMH-1**  
**PROGRAM FISCAL**  
**SUMMARY**

Page \_\_\_\_\_

AGENCY NAME: _____	USE WHOLE DOLLARS.
AGENCY CODE: _____	

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes					
1	Program Type	00071					
2	Program Code (Program Code Index)	00011	( )	( )	( )	( )	( )
	<b>UNITS OF SERVICE</b>						
3	OMH Units of Service	00121					
4	OMRDD Units of Service	00161					
5	OASAS Units of Service	00170					
	<b>EXPENSES*</b>						
6	Personal Services	17010					
7	Vacation Leave Accruals	17020					
8	Fringe Benefits	17030					
9	Other Than Personal Services	17040					
10	Equipment-Provider Paid	17050					
11	Property-Provider Paid	17060					
12	Agency Administration	17080					
13	Adjustments/Non-Allowable Costs	17090					
14	Total Adjusted Expenses (Lines 6-12 minus 13)	17999					
	<b>REVENUES*</b>						
15	Participant Fees (less SSI & SSA)	26010					
16	SSI & SSA	26020					
17	Home Relief/Public Assistance	26030					
18	Medicaid	26040					
19	Medicare	26060					
20	Other Third Parties	26070					
21	OMRDD Residential Room and Board/NYS OPTS	26080					
22	Transportation, Medicaid	26090					
23	Transportation, Other	26100					
24	Sales: Contract Total	26140					
25	Federal Grants (Attach detail)	26160					

\* These amounts are the program type totals for all program/sites aggregated from Schedule CFR-1. This does not apply to agencies filing abbreviated CFR forms.

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**PROGRAM FISCAL**  
**SUMMARY**

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AGENCY NAME: \_\_\_\_\_  
 AGENCY CODE: \_\_\_\_\_

USE WHOLE DOLLARS.

Line No.	COLUMN NUMBER	Cost Codes					
	ITEM DESCRIPTION						
	Program Type	00071					
	Program Code (Program Code Index)	00011	( )	( )	( )	( )	( )
26	State Grants (Attach detail)	26190					
27	LTSE Income Total (OMH and OMRDD only)	26220					
28	Food Stamps (OASAS Only)	26240					
29	Net Deficit Funding (State & LGU Funding only)*	26110					
30	Other (Attach detail for revenue items > \$1,000)	26230					
31	Total Gross Revenues (Sum Lines 15-30)	26999					
<b>GAAP ADJUSTMENTS TO REVENUE**</b>							
32	Participant Allowance	27010					
33	Uncollectible Accounts Receivable	27040					
34	Other (Attach detail for adjustment items > \$1,000)	27045					
35	Total GAAP Adjustments (Sum Lines 32-34)	27049					
36	Net GAAP Revenues (Line 31 minus 35)	27025					
<b>NON-GAAP ADJUSTMENTS TO REVENUE**</b>							
37	Exempt Contract Income	27050					
38	Exempt LTSE Income	27060					
39	Net Deficit Funding***	27070					
40	Other (Attach detail for adjustment items > \$1,000)	27080					
41	Total NON-GAAP Adjustments (Sum Lines 37-40)	27998					
42	Subtotal Adj. to Revenue (Sum Lines 35 & 41)	27999					
43	Total Net Revenues (Line 31 minus 42)	28999					
44	Net Operating Cost (Line 14 minus 43)	29999					

\* Do not include non-funded or voluntary contributions.

\*\* These amounts are the program type totals for all program/sites aggregated from Schedule CFR-1. This does not apply to agencies filing abbreviated CFR forms.

\*\*\* Amounts should equal the corresponding amounts reported as revenue on line 29 above.

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**SCHEDULE DMH-2**  
**AID TO LOCALITIES/  
 DIRECT CONTRACT  
 SUMMARY**

Page \_\_\_\_\_

AGENCY NAME: _____	PREPARED BY: _____	TELEPHONE: (____) _____
AGENCY CODE: _____	<input type="checkbox"/> Please check the box if the preparer changed from the previous submission.	
COUNTY NAME & CODE: _____ (____)	USE WHOLE DOLLARS	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	( )	( )	( )	( )	( )
<b>EXPENSES</b>							
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	18090					
13	Total Adjusted Expenses (Lines 5-11 minus 12)	18999					
<b>REVENUES</b>							
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	OMRDD Residential Room and Board/NYS OPTS	46080					
21	Transportation, Medicaid	46090					
22	Transportation, Other	46100					
23	Sales: Contract Total	46140					
24	Federal Grants (Attach detail)	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.

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**SCHEDULE DMH-2**  
**AID TO LOCALITIES/  
 DIRECT CONTRACT  
 SUMMARY**

Page \_\_\_\_\_

AGENCY NAME: _____	PREPARED BY: _____	TELEPHONE: (____) _____
AGENCY CODE: _____	<input type="checkbox"/> Please check the box if the preparer changed from the previous submission.	
COUNTY NAME & CODE: _____ (____)	USE WHOLE DOLLARS	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 (Attach detail)	46190					
26	LTSE Income Total (OMH and OMRDD only)	46220					
27	Food Stamps (OASAS Only)	46240					
28	Net Deficit Funding (State & LGU Funding only)*	46110					
29	Other (Attach detail)	46230					
30	Total Gross Revenue (Sum Lines 14-29)	46999					
<b>GAAP ADJUSTMENTS TO REVENUE</b>							
31	Participant Allowance	47010					
32	Uncollectible Accounts Receivable	47040					
33	Other (Attach detail for adjustment items > \$1,000)	47045					
34	Total GAAP Adjustments (Sum Lines 31-33)	47049					
35	Net GAAP Revenues (Line 30 minus 34)	47025					
<b>NON-GAAP ADJUSTMENTS TO REVENUE</b>							
36	Exempt Contract Income	47050					
37	Exempt LTSE Income	47060					
38	Net Deficit Funding**	47070					
39	Other (Attach detail)	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					
<b>DEFICIT FUNDING</b>							
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.

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**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: July 1, 2006 to June 30, 2007*

**SCHEDULE DMH-2A**  
**AID TO LOCALITIES/  
 DIRECT CONTRACT  
 EQUIPMENT SUMMARY**

Page \_\_\_\_\_

AGENCY NAME: \_\_\_\_\_  
 AGENCY CODE: \_\_\_\_\_

Line No.	COLUMN NUMBER					
	ITEM DESCRIPTION					
1	PROGRAM TYPE					
2	PROGRAM CODE (Program Code Index)	( )	( )	( )	( )	( )
	EQUIPMENT > \$2,500 (LIST INDIVIDUALLY)					
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23	EQUIPMENT < \$2,500 EACH (AGGREGATE TOTAL)					
24	TOTAL EQUIPMENT					

Note: Do not include any expensed equipment reported in the OTPS line on this schedule.

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**NEW YORK STATE**  
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*For the Period: July 1, 2006 to June 30, 2007*

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

Page \_\_\_\_\_

AGENCY NAME: _____	PREPARED BY: _____	TELEPHONE: (____) _____
AGENCY CODE: _____	<input type="checkbox"/> Please check the box if the preparer changed from the previous submission.	
COUNTY NAME & CODE: _____ (____)	USE WHOLE DOLLARS	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 (OMRDD ONLY)	72999								
9	A. Funding Source Code (Local Assistance)	Index (OMH/OASAS only)	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.