NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2007 to June 30, 2008

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): __ __ __ __ __ __ __ __ __ __ __ __

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.

FEDERAL EMPLOYER ID NUMBER: _____

CHECK THE STATE AGENCY(IES):
☐ OMH
☐ OMRDD
☐ 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 Signature of Chief Executive Officer

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

PLEASE NUMBER ALL PAGES CONSECUTIVELY. LIST THE TOTAL NUMBER OF PAGES SUBMITTED. _____

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: July 1, 2007 to June 30, 2008

SCHEDULE CFR-ii
INDEPENDENT ACCOUNTANT'S REPORT
VOLUNTARY AGENCY or
COUNTY GOVERNMENT

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

We have audited the accompanying balance sheet of the Agency/County as of June 30, 2008 and the accompanying related statements of operations, changes in net assets or equity, and cash flows for the year then ended. These financial statements are the responsibility of the Agency's/County's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe our audit provides a reasonable basis for our opinion.

In our opinion, the aforementioned financial statements present fairly, in all material respects, the financial position of the Agency/County as of June 30, 2008 and the results of its operations, changes in net assets or equity and its cash flows, for the year then ended, in conformity with accounting principles generally accepted in the United States of America.

Our audit was made for the purpose of forming an opinion on the basic financial statements taken as a whole. The information included on Schedules (as applicable) CFR-1, lines 13, 16, 17, 20, 41, 48, 63-67, 69-107; CFR-2; CFR-3; CFR-4; CFR-4A; CFR-5; DMH-1; OMRDD-3; OMRDD-4; OMH-1; and SED-1, which is the responsibility the Agency's/County's management, is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such accompanying information reported on the CFR with Document Control Number _____has been subjected to the auditing procedures applied in the audit of the basic financial statements and, in our opinion, are stated fairly in all material respects when considered in relation to the basic financial statements taken as a whole.

The other information included in this Consolidated Fiscal Report identified by Document Control Number _____, not detailed in the preceding paragraph, was not audited by us and, accordingly, we express no opinion thereon.

We have examined the above detailed schedules' conformity with the applicable instructions relating to the preparation of those schedules contained within the Consolidated Fiscal Reporting and Claiming Manual for the year ended June 30, 2008. The Agency's/County's management is responsible for the schedules' conformity with those instructions. Our responsibility is to express an opinion on the schedules' conformity with those instructions based upon our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence supporting the above referenced CFR schedules' conformity with the applicable instructions and performing such other procedures as we considered necessary in the circumstances including following the procedures contained in Appendix AA of the Consolidated Fiscal Report and Claiming Manual. We believe our examination provides a reasonable basis for our opinion.

In our opinion, the schedules detailed above are, in all material respects, in conformity with the applicable instructions relating to the preparation of the Consolidated Fiscal Report as furnished by the New York State Office of Mental Retardation and Developmental Disabilities, New York State Office of Mental Health, New York State Office of Alcoholism and Substance Abuse, and New York State Education Department for the year ended June 30, 2008.

This report is intended solely for the information and use of management of the Agency/County, the New York State governmental funding agencies, and any funding Counties that are required to receive a copy of this report and is not intended to be and should not be used by anyone other than these specified parties.

The undersigned hereby certifies this opinion and that we have disclosed any and all material facts known to us, disclosure of which is necessary to make this opinion, the basic financial statements and the above referenced CFR schedules not misleading. The undersigned hereby further certifies that we will disclose any material fact discovered by us subsequent to this certification, which existed at the time of this certification and was not disclosed in the basic financial statements or the above referenced CFR schedules, the disclosure of which is necessary to make the basic financial statements or the CFR schedules not misleading and will disclose any material misstatement in said financial statements or the above referenced CFR schedules.

During the period of this professional engagement, at the time of expressing this opinion and during the period covered by the financial statements, we did not have nor were committed to acquire, any direct financial interest or material indirect financial interest in the ownership or operation of the facility and we were not connected in any way with the ownership, financing or operation of the facility as a director, officer or employee, or in any capacity other than as an independent certified public accountant or independent public accountant.

Date CFR-ii Signed | **Signature of Independent Accountant, Firm, or Sole Practitioner** | **CPA Firm Registration Number**

***Date of Report** (Enter the date of the audit report on the financial statements.)

Firm Name

Firm Address

Telephone Number

Firm Contact Person

* The Auditor has not performed any audit procedures since the date of the Auditor's Report on the financial statements.

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: July 1, 2007 to June 30, 2008

SCHEDULE CFR-iiA
INDEPENDENT ACCOUNTANT'S REPORT
VOLUNTARY AGENCY or
COUNTY GOVERNMENT

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

We have examined the following schedules' conformity with the applicable instructions relating to the preparation of those schedules contained within the Consolidated Fiscal Reporting and Claiming Manual of the agency listed above for the year ended June 30, 2008: Schedules (as applicable) CFR-1, lines 13, 16, 17, 20, 41, 48, 63-67, 69-107; CFR-2; CFR-3; CFR-4; CFR-4A; CFR-5; DMH-1; OMRDD-3; OMRDD-4; OMH-1; and SED-1 as reported on the CFR with Document Control Number_____ . Management is responsible for the schedules' conformity with those instructions. Our responsibility is to express an opinion on the schedules' conformity with those instructions based upon our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence supporting the above referenced CFR schedules' conformity with the applicable instructions and performing such other procedures as we considered necessary in the circumstances including following the procedures contained in Appendix AA of the Consolidated Fiscal Report and Claiming Manual for the year ended June 30, 2008. We believe our examination provides a reasonable basis for our opinion.

In our opinion, the above referenced schedules are, in all material respects, in conformity with the applicable instructions relating to the preparation of the Consolidated Fiscal Report as furnished by the New York State Office of Mental Retardation and Developmental Disabilities, New York State Office of Mental Health, New York State Office of Alcoholism and Substance Abuse, and New York State Education Department for the year ended June 30, 2008.

This report is intended solely for the information and use of management of the Agency/County, the New York State governmental funding agencies, and any funding Counties that are required to receive a copy of this report and is not intended to be and should not be used by anyone other than these specified parties.

The undersigned hereby certifies this opinion and that we have disclosed any and all material facts known to us, disclosure of which is necessary to make this opinion and the above referenced CFR schedules not misleading. The undersigned hereby further certifies that we will disclose any material fact discovered by us subsequent to this certification , which existed at the time of this certification and was not disclosed the in the above referenced CFR schedules, the disclosure of which is necessary to make the above referenced CFR schedules not misleading and will disclose any material misstatement in said CFR schedules.

During the period of this professional engagement and at the time of expressing this opinion, we did not have nor were committed to acquire, any direct financial interest or material indirect financial interest in the ownership or operation of the facility and we were not connected in any way with the ownership, financing or operation of the facility as a director, officer or employee, or in any capacity other than as an independent certified public accountant or independent public accountant.

Date of Examination Report

Signature of Independent Accountant, Firm, or Sole Practitioner

CPA Firm Registration Number

Firm Name

Telephone Number

Firm Address

Firm Contact Person

COMPLETE ONLY IF THIS REPORT CONTAINS STATE AID FUNDED PROGRAMS

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2007 to June 30, 2008

SCHEDULE CFR-iii COUNTY/NYC CERTIFICATION STATEMENT

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

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 of Mental Retardation and 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: _____

Please Check State Agency:

☐ OMH ☐ SED

☐ OMRDD

☐ OASAS

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: July 1, 2007 to June 30, 2008

SCHEDULE CFR-1
PROGRAM/SITE
DATA

AGENCY NAME:_____

AGENCY CODE:_____

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

Line No.	COLUMN NUMBER / ITEM DESCRIPTION	Cost Codes					
SECTION A: GENERAL INFORMATION							
1	Program Type	**00070**					
2	Program Code (Program Code Index)	**00010**	( )	( )	( )	( )	( )
3	Program/Site Identification Number	**00050**					
4	Program/Site Name	**00020**					
5	Program/Site Address (Line One)	**00030**					
6	Program/Site Address (Line Two)	**00040**					
7	Medicaid Provider Agreement Number (DMH only)	**00060**					
8	County Code (See Appendix C)	**00080**					
9	Date Site Opened	**00090**					
10	Certified Capacity (OASAS, OMRDD and SED only)	**00100**					
11	Actual Capacity (OMH, OMRDD and SED only)	**00110**					
12	Actual Days Program/Site Open	**00160**					
13	Units of Service	**00120**					
14	Respite or TUBS Units of Service (OMRDD only)	**00130**					
15	Program/Site Square Footage (OASAS and OMRDD only)	**00150**					

Note: Keep program columns consistent throughout the CFR document.

Please Check State Agency:
☐ OMH ☐ SED
☐ OMRDD
☐ OASAS

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2007 to June 30, 2008

SCHEDULE CFR-1
PROGRAM/SITE DATA

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

USE WHOLE DOLLARS.

Line No.	COLUMN NUMBER / ITEM DESCRIPTION	Cost Codes					
	Program Code (Program Code Index)	00010	( )	( )	( )	( )	( )
	Program/Site Identification Number	00050					
SECTION B: EXPENSES							
	PERSONAL SERVICES						
16	Personal Services - Program/Site & Program Admin*	11999					
17	Vacation Accruals - Program/Site & Program Admin*	12999					
	FRINGE BENEFITS						
18	Mandated Fringe Benefits	13200					
19	Non-Mandated Fringe Benefits	13300					
20	Total Fringe Benefits (Sum Lines 18 & 19)	13999					
	OTHER THAN PERSONAL SERVICES (OTPS)						
21	Food	14010					
22	Repairs and Maintenance	14020					
23	Utilities	14030					
24	Transportation Related-Participant**	14040					
25	Staff Travel	14250					
26	Participant Incidentals	14050					
27	Expensed Adaptive Equipment (OMRDD and SED only)	14070					
28	Expensed Equipment	14080					
29	Sub-Contract Raw Materials	14090					
30	Participant Wages-Non-Contract	14100					

*** Must equal program/site specific totals (Support, Direct Care, Clinical, Production, LGU Admin) and Program Administration totals. Do not include agency administration amounts.**
**** Include only expenses associated with this program/site, not expenses associated with a transportation cost center.**

Note: Keep program columns consistent throughout the CFR document.

Please Check State Agency:
☐ OMH ☐ SED
☐ OMRDD
☐ OASAS

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2007 to June 30, 2008

SCHEDULE CFR-1
PROGRAM/SITE DATA

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

USE WHOLE DOLLARS.

Line No.	COLUMN NUMBER / ITEM DESCRIPTION	Cost Codes					
	Program Code (Program Code Index)	**00010**	( )	( )	( )	( )	( )
	Program/Site Identification Number	**00050**					
31	Participant Wages-Contract	**14110**					
32	Participant Fringe Benefits	**14120**					
33	Section 43.04 Services Assessment (OMRDD only)	**14130**					
34	Staff Development	**14140**					
35	Contracted Direct Care and Clinical Personal Svs. (from CFR-4A)	**14150**					
36	Supplies and Materials - Non-Household	**14160**					
37	Household Supplies	**14170**					
38	Telephone	**14190**					
39	Insurance - General	**14260**					
40	Other (Detail Required)	**14998**					
41	Total Other Than Personal Services (Sum Lines 21-40)	**14999**					
	EQUIPMENT-PROVIDER PAID						
42	Lease/Rental Vehicle	**15010**					
43	Lease/Rental Equipment	**15020**					
44	Depreciation-Vehicle	**15040**					
45	Depreciation-Equipment	**15050**					
46	Interest-Vehicle	**15070**					
47	Other (Detail Required)	**15998**					
48	Total Equipment (Sum of Lines 42-47)	**15999**					
	PROPERTY-PROVIDER PAID						
49	Lease/Rental-Real Property	**16010**					
50	Leasehold/Leasehold Improvements	**16020**					
51	Depreciation-Building	**16030**					
52	Depreciation Building/Land Improvements	**16040**					

Note: Keep program columns consistent throughout the CFR document.

Please Check State Agency:
☐ OMH ☐ SED
☐ OMRDD
☐ OASAS

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2007 to June 30, 2008

SCHEDULE CFR-1
PROGRAM/SITE
DATA

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

AGENCY CODE:_____

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

Line No.	COLUMN NUMBER / ITEM DESCRIPTION	Cost Codes					
	Program Code (Program Code Index)	00010	( )	( )	( )	( )	( )
	Program/Site Identification Number	00050					
53	Mortgage/Capital Improvements Interest (Report MCFFA/DASNY Bond Int. on Line 59)	16060					
54	Mortgage Expenses	16070					
55	Insurance-Property & Casualty	16080					
56	Real Estate Taxes	16090					
57	Interest on Capital Indebtedness	16100					
58	Start-up Expenses	16110					
59	MCFFA/DASNY Interest Expense	16120					
60	MCFFA/DASNY Administration Fees	16130					
61	Maintenance in Lieu of Rent (LGU only)	16140					
62	Other (Detail Required)	16998					
63	Total Property-Provider Paid (Sum of Lines 49-62)	16999					
	TOTALS						
64	Total Operating Costs (Sum lines 16, 17, 20, 41 minus 29)	19010					
65	Agency Admin. Alloc.(Line 64 times .__ __ __ __ __ __)*	19050					
66	Adjustments/Non-Allowable Costs	19030					
67	Total Prog/Site Costs (Sum lines 29, 48, 63-65 minus 66)	19060					
	OMRDD Only - Informational						
68a	Other Than To/From Transportation Allocation	19101					
68b	To/From Transportation Allocation	19102					
68c	ICF/DD SED Contract Liability	19103					
68d	ICF/DD Day Services Liability	19104					

*** Enter the applicable 6 digit adjusted ratio value factor from CFR-3.2, line 65 through 69. Agency administration should not be allocated to programs 0190, 0880, 0890 and state agency specific programs which are exempt from agency administration.**

Note: Keep program columns consistent throughout the CFR document.

Please Check State Agency:
☐ OMH ☐ SED
☐ OMRDD
☐ OASAS

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2007 to June 30, 2008

SCHEDULE CFR-1
PROGRAM/SITE DATA

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

USE WHOLE DOLLARS.

Line No.	COLUMN NUMBER / ITEM DESCRIPTION	Cost Codes					
	Program Code (Program Code Index)	**00010**	( )	( )	( )	( )	( )
	Program/Site Identification Number	**00050**					
SECTION C: REVENUES							
69	Participant Fee (less SSI & SSA)	**20010**					
70	SSI & SSA	**20020**					
71	Home Relief/Public Assistance	**20030**					
72	Medicaid	**20040**					
73	Medicare	**20060**					
74	Other Third Parties	**20070**					
75	OMRDD Residential Room and Board/NYS OPTS	**20080**					
76	Transportation, Medicaid	**20090**					
77	Transportation, Other (Detail Required)	**20100**					
78	Sales: Contract Total	**21070**					
79	Federal Grants (Detail Required)	**22040**					
80	State Grants (Detail Required)	**22030**					
81	LTSE Income Total (OMH and OMRDD only)	**22080**					
82	Food Stamps (OASAS Only)/Food Revenue (SED Only)	**22160**					
83	Gifts, Legacies, Bequests, Restricted Donations	**22010**					
84	Section 202/8/811 HUD Funds*	**22020**					
85	Interest/Dividend Income	**22050**					
86	Prior Period Rate Adjustments**	**22090**					
87	VESID Revenue (SED only)	**22100**					
88	LDSS County Revenue (SED only)	**22110**					
89	4402 Revenue (School District In-State) (SED only)	**22120**					

*** For OMRDD programs, if this line is completed, complete Schedule OMRDD-3 (HUD Revenues and Expenses).**
**** Refer to CFR manual for specific instructions.**
Note: Keep program columns consistent throughout the CFR document.

Please Check State Agency:
☐ OMH ☐ SED
☐ OMRDD
☐ OASAS

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2007 to June 30, 2008

SCHEDULE CFR-1
PROGRAM/SITE
DATA

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

USE WHOLE DOLLARS.

Line No.	COLUMN NUMBER / ITEM DESCRIPTION	Cost Codes					
	Program Code (Program Code Index)	**00010**	( )	( )	( )	( )	( )
	Program/Site Identification Number	**00050**					
90	Department of Health Chapter 428 Revenue (SED only)	**22130**					
91	4408 Revenue (School District) (SED only)	**22140**					
92	4410 Revenue (Preschool) (SED only)	**22150**					
93	Net Deficit Funding (State & LGU Funding only)*	**20110**					
94	Other (Detail Required)	**22998**					
95	Gross Revenues (Sum Lines 69-94)	**23999**					
	GAAP ADJUSTMENTS TO REVENUE						
96	Participant Allowance	**24010**					
97	Uncollectible Accounts Receivable	**24040**					
98	Other (Detail Required)	**24996**					
99	Total GAAP Adjustments (Sum Lines 96-98)	**24997**					
100	Net GAAP Revenues (Line 95 minus 99)	**24998**					
	NON-GAAP ADJUSTMENTS TO REVENUE						
101	Exempt Contract Income	**24050**					
102	Exempt LTSE Income	**24060**					
103	Net Deficit Funding**	**24070**					
104	Other (Detail Required)	**24080**					
105	Total NON-GAAP Adjustments (Sum Lines 101-104)	**24097**					
106	**TOTAL ADJ. TO REVENUE (Sum Lines 99 & 105)**	**24999**					
107	**TOTAL NET REVENUES (Line 95 minus 106)**	**25999**					

*** Do not include non-funded or voluntary contributions.**
**** Amounts should equal the corresponding amounts reported as revenue on line 93 above.**
Note: Keep program columns consistent throughout the CFR document.

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2007 to June 30, 2008

SCHEDULE CFR-2
AGENCY FISCAL SUMMARY

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

PLEASE PROVIDE A DETAILED RECONCILIATION OF TOTAL EXPENSES AND REVENUES TO THE AGENCY'S AUDITED FINANCIAL STATEMENTS WHEN REPORTING PERIODS COINCIDE. USE WHOLE DOLLARS.

Line No.	COLUMN NUMBER / ITEM DESCRIPTION / EXPENSES		Cost Codes	1 AGENCY TOTALS (Sum Col. 2-7)	2 OASAS TOTALS	3 OMH TOTALS	4 OMRDD 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.**

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2007 to June 30, 2008

SCHEDULE CFR-3
AGENCY ADMINISTRATION

Page _____

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

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

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	19031	
42	Net Agency Administration (Line 40 minus 41)	19998	

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SCHEDULE CFR-3
AGENCY
ADMINISTRATION

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

AGENCY CODE:_____ USE WHOLE DOLLARS.

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	OMRDD 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	OMRDD 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	OMRDD 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	OMRDD 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 0190, 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 0190, 0880 and 0890 and programs which are exempt from agency administration.
For OMH (line 61) , do not include operating costs for programs 0860, 0870, 1690, 2820, 2830, 2860, 8810 and programs with an "A" program code index (startup).
For OMRDD Specific (line 62), do not include operating costs for programs 2091and 5091.

***** 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.

Please Check State Agency:
☐ OMH ☐ SED
☐ OMRDD
☐ OASAS

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SCHEDULE CFR-4
PERSONAL SERVICES

Page _____

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

REPORT FTE'S TO 3 DECIMAL PLACES.
USE WHOLE DOLLARS.
USE WHOLE HOURS.

Provide all applicable information. Refer to Appendix R for Position Title Codes and Definitions. Check the standard work week or provide the number of hours in the "other" column.
Check the staffing category following the description 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.**
Transfer totals 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. Keep program columns consistent throughout the CFR document.

Please Check State Agency:
☐ OMH ☐ SED
☐ OMRDD
☐ OASAS

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SCHEDULE CFR-4A
CONTRACTED DIRECT CARE AND CLINICAL PERSONAL SERVICES

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

USE WHOLE DOLLARS.
USE WHOLE HOURS.

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.											

Transfer totals to Schedule CFR-1 Line 35 (Program/Site).
Note: Keep program columns consistent throughout the CFR document.

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SCHEDULE CFR-5
TRANSACTIONS WITH RELATED ORGANIZATIONS/INDIVIDUALS

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

SECTION A: ***NOTE: (OASAS and OMRDD 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, OMRDD 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 OMRDD 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 OMRDD 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.**

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SCHEDULE CFR-6
GOVERNING BOARD AND
COMPENSATION SUMMARY

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", attach detail providing 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 the five highest paid employees whose total annualized salary and contracted payment amount (column 7) is in excess of $50,000 per year**

AND

ALL employees whose total annualized salary and contracted payment (column 7) is in excess of $125,000 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 and independent contractors whose annualized salary and/or contracted payment amount is in excess of $50,000. _____**

* **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)**