# NEW YORK STATE

**CONSOLIDATED FISCAL REPORT**

***For the Period: January 1, 2009 to December 31, 2009***

**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:**

**FEDERAL EMPLOYER ID NUMBER:** _____

_____ ( ) _____

**Name** **Telephone Number**

_____

**Title**

**CHECK THE STATE AGENCY(IES):**

☐ OMH
☐ OMRDD
☐ OASAS
☐ SED

_____ ( ) _____

**E-mail Address** **FAX Number**

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

**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.

**COMPLETE ONLY IF THIS REPORT CONTAINS STATE AID FUNDED PROGRAMS**

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
***For the Period: January 1, 2009 to December 31, 2009***

**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:** _____

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

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
*For the Period: January 1, 2009 to December 31, 2009*

**SCHEDULE CFR-4**
**PERSONAL SERVICES**

Page _____

**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 | | | | | | | | | | | | | | | | |
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| 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.**

# NEW YORK STATE

**CONSOLIDATED FISCAL REPORT**

***For the Period: January 1, 2009 to December 31, 2009***

**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.**

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

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
*For the Period: January 1, 2009 to December 31, 2009*

**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 | OMRDD 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
- ☐ OMRDD
- ☐ OASAS

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
*For the Period: January 1, 2009 to December 31, 2009*

**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 OMRDD only) | 46220 | | | | | |
| 27 | Food Stamps (OASAS 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
- ☐ OMRDD
- ☐ OASAS

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
*For the Period: January 1, 2009 to December 31, 2009*

**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 (OMRDD 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.**