

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2018 to December 31, 2018

SCHEDULE CFR-i
AGENCY IDENTIFICATION
AND CERTIFICATION
STATEMENT

Page ____

AGENCY NAME: _____
 AGENCY ADDRESS: _____

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

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

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

SCHOOL CODE (SED ONLY): _____

FEDERAL EMPLOYER ID NUMBER: _____

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

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.

Contact Information for President/Chair, Board of Directors:

 Name

 Title

 E-mail Address

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

 ()
 Telephone Number

 Name and Title

 E-mail Address

 Signature of Chief Executive Officer

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

Rev.

COMPLETE ONLY
IF THIS REPORT
CONTAINS STATE AID
FUNDED PROGRAMS

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2018 to December 31, 2018

SCHEDULE CFR-iii
COUNTY/NYC
CERTIFICATION
STATEMENT

AGENCY NAME: _____	AGENCY CODE: _____
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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)	Signed: _____ (For County/City Operated Local Service Provider)
Title: _____ (Service Provider's Chief Executive Officer)	Title: _____ (LGU's Chief Fiscal Officer)
Date: _____	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, 2018 to December 31, 2018

SCHEDULE CFR-5
TRANSACTIONS WITH RELATED
ORGANIZATIONS/INDIVIDUALS

Page _____

AGENCY NAME: _____	AGENCY CODE: _____	SCHOOL CODE: (SED ONLY) _____
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SECTION A:

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, OMH 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, Allowable Costs column:

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, OMH 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
						To	From	
Line No.	Item No.	Name of Related Party/Individual	Street Address	City, State	Type of Financial Support/Aid	Funding		Funding To/From Amount
1						<input type="checkbox"/>	<input type="checkbox"/>	
2						<input type="checkbox"/>	<input type="checkbox"/>	
3						<input type="checkbox"/>	<input type="checkbox"/>	
4						<input type="checkbox"/>	<input type="checkbox"/>	
5						<input type="checkbox"/>	<input type="checkbox"/>	

Funding State Agency:

- OMH
- OPWDD
- OASAS

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2018 to December 31, 2018

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: _____ (____)	PLEASE CHECK: 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					
17a	Medicaid Fee for Service	46045					
17b	Medicaid Managed Care	46050					
18	Medicare	46060					
19	Other Third Parties	46070					
20	OPWDD Residential Room and Board	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, 2018 to December 31, 2018

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: _____ (____)	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	Provision for Bad Debt - Revenue Deduction	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
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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: _____ (____)	PLEASE CHECK: 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/Year	00220													
5	Total Units of Service	00999													
6	Gross Cost/Unit of Service	70999													
7	Net Cost/Unit of Service	71999													
8	Reserved for Future Use	72999													
9	A. Funding Source Code (Local Assistance)	Index (OMH/OASAS only)	001		001			001			001			001	
10	Number Persons Served/Year	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/Year	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/Year	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.