

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: July 1, 2017 to June 30, 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

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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.

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

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: July 1, 2017 to June 30, 2018*

**SCHEDULE CFR-iii**  
**COUNTY/NYC**  
**CERTIFICATION**  
**STATEMENT**

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

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: \_\_\_\_\_ Signed: \_\_\_\_\_  
(For County/City Operated Local Service Provider)

Title: \_\_\_\_\_ Title: \_\_\_\_\_  
(For Voluntary Local Service Provider) (LGU's Chief Fiscal Officer)

Date: \_\_\_\_\_ Date: \_\_\_\_\_  
(Service Provider's Chief Executive Officer)

**AGENCY CODE:**

**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: \_\_\_\_\_

Local Governmental  
Director of Community Mental Health Services  
\_\_\_\_\_

Date: \_\_\_\_\_ Specify \_\_\_\_\_



**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: July 1, 2017 to June 30, 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 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"/>	

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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:

	<u>NAME</u>	<u>AMOUNT PAID</u>	<u>CONTRACTED PAYMENT AMOUNT</u>	<u>FRINGE BENEFITS</u>	<u>OTHER BENEFITS **</u>	<u>TOTAL COMPENSATION</u>
A.	_____	_____	_____	_____	_____	_____
B.	_____	_____	_____	_____	_____	_____
C.	_____	_____	_____	_____	_____	_____
D.	_____	_____	_____	_____	_____	_____
E.	_____	_____	_____	_____	_____	_____

3. List ALL employees reported under Position Title Codes 601, 602 and 603 (regardless of their total annualized salary) and all employees that received a total annualized salary and contracted payment amount (column 7) in excess of \$125,000.

	(1) <u>NAME</u>	(2) <u>POSITION TITLE CODE *</u>	(3) <u>AMOUNT PAID</u>	(4) <u>FTE</u>	(5) <u>ANNUALIZED SALARY</u>	(6) <u>CONTRACTED PAYMENT AMOUNT</u>	(7) <u>TOTAL ANNUALIZED SALARY AND CONTRACTED PAYMENT</u>	(8) <u>FRINGE BENEFITS</u>	(9) <u>OTHER BENEFITS **</u>
A.	_____	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____	_____
B.	_____	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____	_____
C.	_____	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____	_____
D.	_____	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____	_____
E.	_____	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____	_____

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

	(1) <u>NAME</u>	(2) <u>TYPE OF SERVICE</u>	(3) <u>AMOUNT PAID</u>
A.	_____	_____	_____
B.	_____	_____	_____
C.	_____	_____	_____
D.	_____	_____	_____
E.	_____	_____	_____

\* 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 Costs, Tuition Reimbursement, Severance Benefits)

Funding State Agency:

- OMH
- OPWDD
- OASAS

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
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**SCHEDULE DMH-2**  
**AID TO LOCALITIES/  
 DIRECT CONTRACT  
 SUMMARY**

Page \_\_\_\_\_

AGENCY NAME: _____	PREPARED BY: _____	TELEPHONE: (____) _____
AGENCY CODE: _____	<input type="checkbox"/>	
COUNTY NAME & CODE: _____ (____)	Please check the box if the preparer changed from the previous submission. <input type="checkbox"/> FINAL CLAIM _____	

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes				
1	Accounting Method			PLEASE CHECK:		
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 (Detail Required)	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				
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**  
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**SCHEDULE DMH-2**  
**AID TO LOCALITIES/  
 DIRECT CONTRACT  
 SUMMARY**

Page \_\_\_\_\_

AGENCY NAME: _____	PREPARED BY: _____	TELEPHONE: (____) _____
AGENCY CODE: _____	<input type="checkbox"/>	
COUNTY NAME & CODE: _____ (____)	Please check the box if the preparer changed from the previous submission.	ESTIMATED CLAIM ____ FINAL CLAIM ____

Line No.	COLUMN NUMBER ITEM DESCRIPTION	Cost Codes	PLEASE CHECK:	ESTIMATED CLAIM	FINAL CLAIM
	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			(
<b>GAAP ADJUSTMENTS TO REVENUE</b>					
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			
<b>NON-GAAP ADJUSTMENTS TO REVENUE</b>					
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			
<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.

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
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.