NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2020 to December 31, 2020

AGENCY NAME: __________________________________________
AGENCY ADDRESS: __________________________________________

AGENCY CODE: __________ COUNTY NAME: __________
COUNTY CODE: __________

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

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

SCHOOL CODE (SED ONLY): __________________________

FEDERAL EMPLOYER ID NUMBER: __________________________

CERTIFIED FINANCIAL STATEMENT REPORTING PERIOD: __________________________

CHECK THE STATE AGENCY(IES):
☐ OMH ☐ DOH
☐ OPWDD ☐ OCFS
☐ 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 __________________________ Secondary 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 __________________________

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

Signature of Chief Executive Officer __________________________

Date __________________________

(-) Name and Title __________________________ Telephone Number __________________________

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 __________________________

(-) Name and Title __________________________

E-mail Address __________________________

Rev. Dec. 2020
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 Addiction Services and Supports, 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)
Name: _________________________________________
(First and Last Name of Service Provider's Chief Executive Officer)
Title: _________________________________________
(Service Provider's Chief Executive Officer)
Date: ____________________________

(For County/City Operated Local Service Provider)
Name: _________________________________________
(First and Last Name of LGU's Chief Fiscal Officer)
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)
Name: __________________________________________________________
(First and Last Name of Director of Community Mental Health Services)
Local Governmental Unit: __________________________________________
(Specify)
Date: ____________________________

SCHEDULE CFR-iii
COUNTY/NYC
CERTIFICATION STATEMENT
Page ___
NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2020 to December 31, 2020

SCHEDULE CFR-iv
SUPPLEMENTAL
ATTESTATION SCHEDULE

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

Agency Name: ____________________________
Document Control Number (DCN): ____________
FEIN: ____________

Please answer all questions below regarding the activities of your organization.

1. a) filed its most recently required federal tax form 990? □ Yes □ No □ N/A
   b) If "No", what was the end date of the period covered by the most recent filing? ________________

2. a) filed its most recently required NYS form CHAR500? □ Yes □ No □ N/A
   b) If "No", what was the end date of the period covered by the most recent filing? ________________

3. filed all required Consolidated Fiscal Reports (CFRs) to date, including all required certification schedules? □ Yes □ No □ N/A

4. submitted financial statements corresponding with the CFR reporting period, or those with an end date within the CFR reporting period? □ Yes □ No □ N/A

5. accurately reported all revenue received, including Medicaid and Other Third Parties revenue? □ Yes □ No □ N/A

6. properly disclosed all financial transactions with related organizations/individuals on schedule CFR-5? □ Yes □ No □ N/A

7. accurately calculated agency administration expenses using the ratio value methodology on the CFR, including on schedule DMH-2? □ Yes □ No □ N/A

8. a) reported and adjusted out all non-allowable expenses on the CFR core and claiming documents as required by your funding agency? □ Yes □ No □ N/A
   b) OASAS Service Providers Only: adjusted out all OASAS non-reimbursable expenses from the OASAS State Aid claiming schedules? □ Yes □ No □ N/A

9. complied with all required competitive bidding requirements as detailed in your funding agency’s administrative and/or fiscal guidelines for funded providers? □ Yes □ No □ N/A

10. remained current with all federal, state, and local employment tax obligations and workers’ compensation requirements? □ Yes □ No □ N/A

11. a) OASAS and OPWDD Service Providers: remained current with all rental payments and other occupancy requirements? □ Yes □ No □ N/A
   b) OMH Service Providers Only: remained current with all rental payments and other occupancy requirements related to residents in OMH residential programs? □ Yes □ No □ N/A

12. OASAS Service Providers Only: complied with all aspects of your property leasing requirements? □ Yes □ No □ N/A

Under the penalties prescribed in accordance with Article 175 of the New York State Penal Law (False Written Statements), I hereby certify that the information provided above is true and correct to the best of my knowledge. I further attest that there are records and documentation that support the responses given to all questions and that said documentation will be kept in the custody of the above-named agency for the prescribed records retention period. I understand that failure to timely submit an accurately and properly completed Schedule CFR-iv may result in a delay of the approval and acceptance of the submitted Consolidated Fiscal Report and the final year-end state aid claiming schedules DMH-2 and DMH-3 for this and future fiscal reporting periods. Additionally, I acknowledge and accept that non-compliance with the requirement to timely submit a properly and accurately completed Schedule CFR-iv may, at the sole discretion of the NYS funding agency, delay the provision of state aid funding to the above-named organization and may also have an adverse impact on the above-named Agency’s issued Operating Certificate.

Name: ____________________________
Signature of Chief Executive Officer: ____________________________
E-Mail Address: ____________________________

Official Title: ____________________________
Telephone Number: ____________________________
Date Signed: ____________________________

CFR-iv
Rev. Dec. 2020
<table>
<thead>
<tr>
<th>Line No.</th>
<th>COLUMN NUMBER</th>
<th>ITEM DESCRIPTION</th>
<th>Cost Codes</th>
<th>1 AGENCY TOTALS</th>
<th>2 OASAS TOTALS</th>
<th>3 OMH TOTALS</th>
<th>4 OPWDD TOTALS</th>
<th>5 SED TOTALS</th>
<th>6 DOH TOTALS</th>
<th>7 OCFS TOTALS</th>
<th>8 SHARED PROGRAM TOTALS</th>
<th>9 OTHER PROGRAMS TOTALS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>EXPENSES</td>
<td>Personal Services</td>
<td>CFR-1, Line 16</td>
<td>31999</td>
<td></td>
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<td>2</td>
<td></td>
<td>Vacation Leave Accruals</td>
<td>CFR-1, Line 17</td>
<td>32999</td>
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<td>3</td>
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<td>Fringe Benefits</td>
<td>CFR-1, Line 20</td>
<td>33999</td>
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<td>4</td>
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<td>OTPS</td>
<td>CFR-1, Line 41</td>
<td>34999</td>
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<td>5</td>
<td></td>
<td>Equipment-Provider Paid</td>
<td>CFR-1, Line 48</td>
<td>35999</td>
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<td>7</td>
<td></td>
<td>Net Agency Admin.</td>
<td>CFR-1, Line 65</td>
<td>38050</td>
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<td>8</td>
<td></td>
<td>Adj./Non-Allow. Costs</td>
<td>CFR-1, Line 66</td>
<td>38030</td>
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<td>9</td>
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<td>Total Adj. Expenses</td>
<td>(Sum Lines 1-7 minus 8)</td>
<td>38999</td>
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<td>10</td>
<td>REVENUES</td>
<td>Gross Revenues</td>
<td>CFR-1, Line 95</td>
<td>40999</td>
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<td>11</td>
<td></td>
<td>GAAP Adj. to Revenue</td>
<td>CFR-1, Line 99</td>
<td>43999</td>
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<td>12</td>
<td></td>
<td>Net GAAP Revenues</td>
<td>(Line 10 minus Line 11)</td>
<td>44999</td>
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</tbody>
</table>

* These amounts are not detailed elsewhere in the CFR and, therefore, will not crossfoot to CFR-1.
Complete the following schedule using data from your Financial Statements submitted in accordance with Section 2.0 and 6.0 of the CFR Manual and data from the underlying year-end-adjusted accounting records that support these Financial Statements.

### Section A - Reports

<table>
<thead>
<tr>
<th>1. Year-End Date of Financial Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. CPA or Audit Firm (skip if statements are not audited or reviewed)</td>
</tr>
<tr>
<td>3. Opinion – use drop-down (skip if statements are not audited)</td>
</tr>
<tr>
<td>4. Type of Financial Statements</td>
</tr>
</tbody>
</table>

This is a drop-down with the following selections:
- Unmodified
- Qualified
- Disclaimer
- Adverse

### Section B - Statement of Financial Position/Balance Sheet

| 5. Cash and Cash Equivalents |
| 6. Accounts Receivable, Net |
| 7. Related Party Receivables |
| 8. Investments |
| 9. Property & Equipment, Net |
| 10. Total Assets |
| 11. Accounts Payable and Accrued Liabilities |
| 12. Debt - Current Portion |
| 13. Long-Term Debt, Net of Current Portion |
| 14. Total Liabilities |
| 15. Total Current Assets |
| 16. Total Current Liabilities |
| 17. Retained Earnings, Beginning of the Year |
| 18. Retained Earnings, End of the Year |

<table>
<thead>
<tr>
<th>Total</th>
<th>Without Donor Restrictions</th>
<th>With Donor Restrictions</th>
</tr>
</thead>
</table>

### Section C - Statement of Activities/Income Statement

| 23. Total Revenue and Total Gains |
| 24. Management and General |
| 25. Interest Expense |
| 26. Income Tax Expense |
| 27. Total Expenses and Total Losses |

<table>
<thead>
<tr>
<th>Operating Transactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Operating Revenues and Operating Gains</td>
</tr>
<tr>
<td>B. Operating Expenses and Operating Losses</td>
</tr>
</tbody>
</table>

### Section D - Line of Credit & Debt

| 29. Maximum Borrowing Potential |
| 30. Loan Balance at Year End |
| 31. Interest Rate at Year End |

<table>
<thead>
<tr>
<th>Operating Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All Other Lines of Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line of Credit 1</td>
</tr>
<tr>
<td>Line of Credit 2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the current reporting period, has your agency:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Refinanced or restructured debt in order to extend the term of the repayment schedule?</td>
</tr>
<tr>
<td>B. Converted short-term debt into long-term debt?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the current reporting period, has your agency:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Is the agency in compliance with all debt covenants with their lender(s) on their lines of credit?</td>
</tr>
<tr>
<td>B. If S3A is &quot;No&quot;, did the agency get a waiver from the creditor?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Going Concern</th>
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<tbody>
<tr>
<td>In the audited financial statements, was there substantial doubt about your entity’s ability to continue as a going concern?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>PROGRAM/SITE-PROGRAM ADMIN./LGU ADMIN. (Position Title Codes 100-599 and 700-799 series)</th>
<th>AGENCY ADMINISTRATION (Position Title Codes 600-699 series)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COLUMN NUMBER</td>
<td></td>
</tr>
<tr>
<td>PROGRAM CODE ** (PROGRAM CODE INDEX)</td>
<td>( ) ( ) ( ) ( ) ( )</td>
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<tr>
<td>PROGRAM/SITE IDENTIFICATION NUMBER **</td>
<td></td>
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<tr>
<td>PROGRAM/SITE NAME</td>
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<tr>
<td>PROGRAM/SITE ADDRESS (Line One)</td>
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<tr>
<td>PROGRAM/SITE ADDRESS (Line Two)</td>
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<tr>
<td>COUNTY CODE</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Position Title</th>
<th>Standard Work Week</th>
<th>Hours Paid</th>
<th>FTE</th>
<th>Hours Paid</th>
<th>FTE</th>
<th>Hours Paid</th>
<th>FTE</th>
<th>Hours Paid</th>
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<th>Hours Paid</th>
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<tr>
<td></td>
<td>35</td>
<td>37.5</td>
<td>40</td>
<td>Other</td>
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</table>

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: FTEs do not get transferred.
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, SED, DOH and/or OCFS 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, OPWDD, DOH and OCFS 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:

<table>
<thead>
<tr>
<th>Line No.</th>
<th>Item No.</th>
<th>PROGRAM/SITES AFFECTED</th>
<th>DESCRIPTION OF TRANSACTION</th>
<th>NAME OF RELATED ORGANIZATION/INDIVIDUAL</th>
<th>RELATIONSHIP TO PROVIDER*</th>
<th>AMOUNT OF TRANSACTION REPORTED</th>
<th>ALLOWABLE COSTS (COL. 7 MINUS 8)</th>
<th>ADJUSTMENTS TO COSTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
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</table>

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:

<table>
<thead>
<tr>
<th>Line No.</th>
<th>Item No.</th>
<th>PROGRAM/SITES AFFECTED</th>
<th>ENTER PROG/SITE ID# (CODE) OR ADMIN.</th>
<th>DEPRECIATION</th>
<th>MORTGAGE INTEREST</th>
<th>INSURANCE</th>
<th>PROPERTY TAXES</th>
<th>OTHER (SPECIFY)</th>
<th>TOTAL ALLOWABLE COSTS</th>
</tr>
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<tbody>
<tr>
<td>1</td>
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SECTION D:

(This section applies only to OASAS, OMH, OPWDD, DOH and OCFS 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.

<table>
<thead>
<tr>
<th>Line No.</th>
<th>Item No.</th>
<th>Name of Related Party/Individual</th>
<th>Street Address</th>
<th>City, State</th>
<th>Type of Financial Support/Aid</th>
<th>Funding To</th>
<th>Funding From</th>
<th>Funding To/From Amount</th>
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<tr>
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</table>
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:

<table>
<thead>
<tr>
<th>NAME</th>
<th>AMOUNT PAID</th>
<th>CONTRACTED PAYMENT AMOUNT</th>
<th>FRINGE BENEFITS</th>
<th>OTHER BENEFITS **</th>
<th>TOTAL COMPENSATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>NAME</th>
<th>POSITION TITLE CODE *</th>
<th>AMOUNT PAID</th>
<th>FTE</th>
<th>ANNUALIZED SALARY</th>
<th>CONTRACTED PAYMENT AMOUNT</th>
<th>TOTAL ANNUALIZED SALARY AND CONTRACTED PAYMENT</th>
<th>FRINGE BENEFITS</th>
<th>OTHER BENEFITS **</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>(1) NAME</th>
<th>(2) TYPE OF SERVICE</th>
<th>(3) AMOUNT PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* 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)
<table>
<thead>
<tr>
<th>Line No.</th>
<th>COLUMN NUMBER</th>
<th>Cost Codes</th>
<th>ITEM DESCRIPTION</th>
<th>UNITS OF SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Program Type</td>
<td>00071</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Program Code (Program Code Index)</td>
<td>00011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>OMH Units of Service</td>
<td>00121</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>OPWDD Units of Service</td>
<td>00161</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>OASAS Units of Service</td>
<td>00170</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### EXPENSES*

<table>
<thead>
<tr>
<th>Line No.</th>
<th>Cost Codes</th>
<th>ITEM DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td></td>
<td>Personal Services</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>Vacation Leave Accruals</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>Fringe Benefits</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>Other Than Personal Services</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Equipment-Provider Paid</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>Property-Provider Paid</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>Agency Administration</td>
</tr>
<tr>
<td>13</td>
<td></td>
<td>Adjustments/Non-Allowable Costs</td>
</tr>
<tr>
<td>14</td>
<td></td>
<td>Total Adjusted Expenses (Lines 6-12 minus 13)</td>
</tr>
</tbody>
</table>

### REVENUES*

<table>
<thead>
<tr>
<th>Line No.</th>
<th>Cost Codes</th>
<th>ITEM DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td></td>
<td>Participant Fees (less SSI &amp; SSA)</td>
</tr>
<tr>
<td>16</td>
<td></td>
<td>SSI &amp; SSA</td>
</tr>
<tr>
<td>17</td>
<td></td>
<td>Home Relief/Public Assistance</td>
</tr>
<tr>
<td>18a</td>
<td></td>
<td>Medicaid Fee for Service</td>
</tr>
<tr>
<td>18b</td>
<td></td>
<td>Medicaid Managed Care</td>
</tr>
<tr>
<td>19</td>
<td></td>
<td>Medicare</td>
</tr>
<tr>
<td>20</td>
<td></td>
<td>Other Third Parties</td>
</tr>
<tr>
<td>21</td>
<td></td>
<td>OPWDD Residential Room and Board</td>
</tr>
<tr>
<td>22</td>
<td></td>
<td>Transportation, Medicaid</td>
</tr>
<tr>
<td>23</td>
<td></td>
<td>Transportation, Other</td>
</tr>
<tr>
<td>24</td>
<td></td>
<td>Sales: Contract Total</td>
</tr>
<tr>
<td>25</td>
<td></td>
<td>Federal Grants (Detail Required)</td>
</tr>
</tbody>
</table>

* 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.
<table>
<thead>
<tr>
<th>Line No.</th>
<th>COLUMN NUMBER</th>
<th>ITEM DESCRIPTION</th>
<th>Cost Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Program Type (Program Code Index)</td>
<td>00011</td>
</tr>
<tr>
<td>26</td>
<td></td>
<td>State Grants (Detail Required)</td>
<td>26190</td>
</tr>
<tr>
<td>27</td>
<td></td>
<td>LTSE Income Total (OMH and OPWDD only)</td>
<td>26220</td>
</tr>
<tr>
<td>28</td>
<td></td>
<td>SNAP (OASAS and OPWDD Only)</td>
<td>26240</td>
</tr>
<tr>
<td>29</td>
<td></td>
<td>Net Deficit Funding (State &amp; LGU Funding only)*</td>
<td>26110</td>
</tr>
<tr>
<td>30</td>
<td></td>
<td>Other (Detail Required)</td>
<td>26230</td>
</tr>
<tr>
<td>31</td>
<td></td>
<td>Total Gross Revenues (Sum Lines 15-30)</td>
<td>26999</td>
</tr>
<tr>
<td>32</td>
<td></td>
<td>Participant Allowance</td>
<td>27010</td>
</tr>
<tr>
<td>33</td>
<td></td>
<td>Provision for Bad Debt - Revenue Deduction</td>
<td>27040</td>
</tr>
<tr>
<td>34</td>
<td></td>
<td>Other (Detail Required)</td>
<td>27045</td>
</tr>
<tr>
<td>35</td>
<td></td>
<td>Total GAAP Adjustments (Sum Lines 32-34)</td>
<td>27049</td>
</tr>
<tr>
<td>36</td>
<td></td>
<td>Net GAAP Revenues (Line 31 minus 35)</td>
<td>27025</td>
</tr>
<tr>
<td>37</td>
<td></td>
<td>Exempt Contract Income</td>
<td>27050</td>
</tr>
<tr>
<td>38</td>
<td></td>
<td>Exempt LTSE Income</td>
<td>27060</td>
</tr>
<tr>
<td>39</td>
<td></td>
<td>Net Deficit Funding***</td>
<td>27070</td>
</tr>
<tr>
<td>40</td>
<td></td>
<td>Other (Detail Required)</td>
<td>27080</td>
</tr>
<tr>
<td>41</td>
<td></td>
<td>Total NON-GAAP Adjustments (Sum Lines 37-40)</td>
<td>27998</td>
</tr>
<tr>
<td>42</td>
<td></td>
<td>Subtotal Adj. to Revenue (Sum Lines 35 &amp; 41)</td>
<td>27999</td>
</tr>
<tr>
<td>43</td>
<td></td>
<td>Total Net Revenues (Line 31 minus 42)</td>
<td>28999</td>
</tr>
<tr>
<td>44</td>
<td></td>
<td>Net Operating Cost (Line 14 minus 43)</td>
<td>29999</td>
</tr>
</tbody>
</table>

* 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.
**NEW YORK STATE**

**CONSOLIDATED FISCAL REPORT**

*For the Period: January 1, 2020 to December 31, 2020*

---

**AGENCY NAME:**

**PREPARED BY:**

**TELEPHONE:** (___) _________

---

**COUNTY NAME & CODE:** ______________________(____)

**PREPARED BY:** _____________________________________________

---

**PLEASE CHECK:**

**FINAL CLAIM**

---

<table>
<thead>
<tr>
<th>Line No.</th>
<th>COLUMN NUMBER</th>
<th>ITEM DESCRIPTION</th>
<th>Cost Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>Accounting Method</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>State Contract Number / LGU Contract Number *</td>
<td>00200</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Program Type</td>
<td>00072</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Program Code (Program Code Index)</td>
<td>00012  ( ) ( ) ( ) ( ) ( )</td>
</tr>
</tbody>
</table>

**EXPENSES**

| 5        | Vacation Leave Accruals ** | 18020 |
| 6        | Fringe Benefits | 18030 |
| 7        | Other Than Personal Services (OTPS) | 18040 |
| 8        | Equipment-Provider Paid *** | 18050 |
| 9        | Property-Provider Paid **** | 18060 |
| 10       | Agency Administration | 18080 |
| 11       | Adjustments/Non-Allowable Costs (Detail Required) | 18090 |
| 12       | Total Adjusted Expenses (Lines 5-11 minus 12) | 18999 |

**REVENUES**

| 13       | Participant Fees (less SSI & SSA) | 46010 |
| 14       | SSI & SSA | 46020 |
| 15       | Home Relief/Public Assistance | 46030 |
| 16       | Medicaid Fee for Service | 46045 |
| 17a      | Medicaid Managed Care | 46050 |
| 17b      | Medicare | 46060 |
| 18       | Other Third Parties | 46070 |
| 19       | OPWDD Residential Room and Board | 46080 |
| 20       | Transportation, Medicaid | 46090 |
| 21       | Transportation, Other | 46100 |
| 22       | Sales: Contract Total | 46140 |
| 23       | 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.

---

DMH-2.1
Rev. Dec. 2020
### Funding State Agency

- **OMH**
- **OPWDD**
- **OASAS**

**NEW YORK STATE**

**CONSOLIDATED FISCAL REPORT**

*For the Period: January 1, 2020 to December 31, 2020*

**SCHEDULE DMH-2**

**AIM TO LOCALITIES/**

**DIRECT CONTRACT**

**SUMMARY**

**Page ____**

**AGENCY NAME:** ______________________________________

**PREPARED BY:** ______________________________________

**TELEPHONE:** (____) _______________

☐ Please check the box if the preparer changed from the previous submission.

**AGENCY CODE:** ______________________________________

**COUNTY NAME & CODE:** _______________________(____)

<table>
<thead>
<tr>
<th>Line No.</th>
<th>COLUMN NUMBER</th>
<th>ITEM DESCRIPTION</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Cost</strong></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td><strong>Line 13 minus 12</strong></td>
<td>49999</td>
</tr>
<tr>
<td>15</td>
<td></td>
<td><strong>Net Operating Costs</strong></td>
<td>49999</td>
</tr>
<tr>
<td>16</td>
<td></td>
<td><strong>DEFICIT FUNDING</strong></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td></td>
<td><strong>State Share</strong></td>
<td>60010</td>
</tr>
<tr>
<td>18</td>
<td></td>
<td><strong>Local Government Share</strong></td>
<td>60020</td>
</tr>
<tr>
<td>19</td>
<td></td>
<td><strong>Service Provider Share (Voluntary Contributions)</strong></td>
<td>60030</td>
</tr>
<tr>
<td>20</td>
<td></td>
<td><strong>Total Approved Deficit Funding (Sum lines 44 - 46)</strong></td>
<td>60039</td>
</tr>
<tr>
<td>21</td>
<td></td>
<td><strong>Non-Funded</strong></td>
<td>60040</td>
</tr>
<tr>
<td>22</td>
<td></td>
<td><strong>Total Net Deficit (Sum Lines 47-48)</strong></td>
<td>60999</td>
</tr>
</tbody>
</table>

* Do not include non-funded or voluntary contributions.

**DMH-2**

**Rev. Dec. 2020**
<table>
<thead>
<tr>
<th>Line No.</th>
<th>COLUMN NUMBER</th>
<th>ITEM DESCRIPTION</th>
<th>Cost Codes</th>
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</tr>
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<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Accounting Method</td>
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<tr>
<td>2</td>
<td>2</td>
<td>Program Type</td>
<td>00073</td>
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</tr>
<tr>
<td>3</td>
<td>3</td>
<td>Program Code (Program Code Index)</td>
<td>00013 ( ) ( ) ( ) ( ) ( )</td>
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<tr>
<td>4</td>
<td>4</td>
<td>Total Persons Served/Year</td>
<td>00220</td>
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</tr>
<tr>
<td>5</td>
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<td>Total Units of Service</td>
<td>00999</td>
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</tr>
<tr>
<td>6</td>
<td>6</td>
<td>Gross Cost/Unit of Service</td>
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<td>7</td>
<td>7</td>
<td>Net Cost/Unit of Service</td>
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<td>Reserved for Future Use</td>
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<td>A. Funding Source Code (Local Assistance)</td>
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<td>Number Units of Service</td>
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<td>Total Adjusted Expenses</td>
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<td>13</td>
<td>13</td>
<td>Less Applied Net Revenue</td>
<td>61999</td>
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<td>State Contract Number / LGU Contract Number *</td>
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<td>Total Adjusted Expenses</td>
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<td>Net Operating Costs</td>
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<td>29</td>
<td>State Contract Number / LGU Contract Number *</td>
<td>00203</td>
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</tbody>
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* For direct contracts, enter the State Contract Number. For local contracts, enter the local Contract Number, if applicable.