

**NEW YORK STATE**  
CONSOLIDATED FISCAL REPORT  
For the Period: July 1, 2020 to June 30, 2021

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  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 President/Chair changed from the prior reporting period.

---

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.

CFR-i  
July 2021

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: July 1, 2020 to June 30, 2021*

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

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|                    |                    |                               |
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| AGENCY NAME: _____ | AGENCY CODE: _____ | SCHOOL CODE (SED ONLY): _____ |
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**Management's Responsibility for the Financial Statements**

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

**Auditor's Responsibility**

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 from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall financial statement presentation.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

**Opinion**

In our opinion, the financial statements referred to above present fairly, in all material respects, the statement of financial position of (Agency Name) at December 31, 2020, and the changes in its net assets or equity and its cash flows for the year then ended in conformity with U.S. generally accepted accounting principles.

**Other Matters**

**Supplementary Information**

Our audit was conducted for the purpose of forming an opinion on the financial statements 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; CFR2A; CFR-3; CFR-4; CFR-4A; CFR-5; CFR-6, Section 3; DMH-1; OMH-1; OMH-4; OPWDD-5; SED-1; SED-4 and SUPP-1, is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information reported on the CFR with Document Control Number \_\_\_\_\_ has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects, in relation to the financial statements as a whole. The other information included in the Consolidated Fiscal Report identified by Document Control Number \_\_\_\_\_, was not audited by us, and, accordingly, we express no opinion thereon.

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: July 1, 2020 to June 30, 2021*

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

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|--------------------|--------------------|-------------------------------|
| AGENCY NAME: _____ | AGENCY CODE: _____ | SCHOOL CODE (SED ONLY): _____ |
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Report on Other Legal and Regulatory Requirements

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 (Agency Name) for the year ended December 31, 2020: Schedules CFR-1, lines 13, 16, 17, 20, 41, 48, 63-67, 69-107; CFR-2; CFR-2A; CFR-3; CFR-4; CFR-4A; CFR-5; CFR-6, Section 3; DMH-1; OMH-1; OMH-4; OPWDD-5; SED-1; SED-4, and SUPP-1 (collectively, "CFR Schedules") as reported on the CFR with Document Control Number \_\_\_\_\_. (Agency Name)'s management is responsible for the CFR schedules' conformity with the applicable instructions relating to the preparation of the Consolidated Fiscal Report as furnished by the New York State Office for People With Developmental Disabilities, New York State Office of Mental Health, New York State Office of Addiction Services and Supports, New York State Education Department, New York State Department of Health, and New York State Office of Childrean and Family Services for the year ended December 31, 2020. Our responsibility is to express an opinion on the CFR 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. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the CFR schedules are in conformity with the applicable instructions relating to the preparation of the Consolidated Fiscal Report as furnished by the New York State Office for People With Developmental Disabilities, New York State Office of Mental Health, New York State Office of Addiction Services and Supports, New York State Education Department, New York State Department of Health, and New York State Office of Children and Family Services for the year ended December 31, 2020 in all material respects. An examination involves performing procedures to obtain evidence about the CFR schedules. The nature, timing and extent of the procedures selected depend on our judgement, including an assessment of the risks of material misstatement of the CFR schedules, whether due to fraud or error, and such procedures included in Appendix AA of the Consolidated Fiscal Reporting and Claiming Manual for the year ended December 31, 2020. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

In our opinion, the above referenced CFR schedules are prepared in conformity with the applicable instructions relating to the preparation of the Consolidated Fiscal Report as furnished by the New York State Office for People With Developmental Disabilities, New York State Office of Mental Health, New York State Office of Addiction Services and Supports, New York State Education Department, New York State Department of Health, and New York State Office of Children and Family Services for the year ended December 31, 2020, in all material respects.

This report is intended solely for the information and use of the Agency's management, 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 staten

\_\_\_\_\_  
Firm Name

\_\_\_\_\_  
Firm Address

\_\_\_\_\_  
Telephone #

\_\_\_\_\_  
Firm Contact Person

Rev.

CFR-ii.2  
July 2021

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: July 1, 2020 to June 30, 2021*

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

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|                    |                    |                               |
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| AGENCY NAME: _____ | AGENCY CODE: _____ | SCHOOL CODE (SED ONLY): _____ |
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In our opinion, the above referenced CFR schedules are prepared in conformity with the applicable instructions relating to the preparation of the Consolidated Fiscal Report as furnished by the New York State Office for People With Developmental Disabilities, New York State Office of Mental Health, New York State Office of Addiction Services and Supports, New York State Education Department, New York State Department of Health, and New York State Office of Children and Family Services for the year ended December 31, 2020, in all material respects.

This report is intended solely for the information and use of the Agency's management, 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 in the above referenced CFR schedules, the disclosure of which is necessary to make the CFR schedules not misleading and will disclose any material misstatement in the above referenced CFR schedules.

During the period of this professional engagement, 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, 2020 to June 30, 2021*

SCHEDULE CFR-iii  
COUNTY/NYC  
CERTIFICATION  
STATEMENT

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|                    |                    |
|--------------------|--------------------|
| 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)

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

Name: \_\_\_\_\_  
(First and Last Name of Service Provider's Chief Executive Officer)

Name: \_\_\_\_\_  
(First and Last Name of LGU's Chief Fiscal Officer)

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

Name: \_\_\_\_\_  
(First and Last Name of Director of Community Mental Health Services)

Local Governmental Unit: \_\_\_\_\_  
(Specify)

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

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: July 1, 2020 to June 30, 2021*

SCHEDULE CFR-iv  
SUPPLEMENTAL  
ATTESTATION SCHEDULE

**TYPE OF OWNERSHIP:**

NOT-FOR-PROFIT

PROPRIETARY

|                                |              |
|--------------------------------|--------------|
| Agency Name:                   | Agency Code: |
| Document Control Number (DCN): | FEIN:        |

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

**Has 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:                                 | Official Title: | Telephone Number: |
| Signature of Chief Executive Officer: | E-Mail Address: | Date Signed:      |

- Funding State Agency:
- OMH     SED  
 OPWDD     DOH  
 OASAS     OCFS

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: July 1, 2020 to June 30, 2021*

**SCHEDULE CFR-1**  
**PROGRAM/SITE**  
**DATA**

Page \_\_\_\_\_

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

| Line No.                              | COLUMN NUMBER<br>ITEM DESCRIPTION                       | Cost Codes |     |     |     |     |     |
|---------------------------------------|---|------------|-----|-----|-----|-----|-----|
| <b>SECTION A: GENERAL INFORMATION</b> |   |            |     |     |     |     |     |
| 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      |     |     |     |     |     |
| 7a                                    | Medicaid Provider Agreement Number (DMH only)           | 00060      |     |     |     |     |     |
| 7b                                    | National Provider ID Number (DMH Only)                  | 00061      |     |     |     |     |     |
| 8                                     | County Code (See Appendix C)                            | 00080      |     |     |     |     |     |
| 9                                     | Date Site Opened  | 00090      |     |     |     |     |     |
| 10                                    | Certified Capacity (OASAS, OPWDD and SED only)          | 00100      |     |     |     |     |     |
| 11                                    | Actual Capacity (OMH, OPWDD and SED only)               | 00110      |     |     |     |     |     |
| 12                                    | Actual Days Program/Site Open                           | 00160      |     |     |     |     |     |
| 13                                    | Total Units of Service                                  | 00120      |     |     |     |     |     |
| 13a                                   | Medicaid Fee for Service Units of Service               | 00114      |     |     |     |     |     |
| 13b                                   | Medicaid Managed Care Units of Service                  | 00115      |     |     |     |     |     |
| 13c                                   | All Other Units of Service                              | 00116      |     |     |     |     |     |
| 14                                    | Respite or TUBS Units of Service (OPWDD only)           | 00130      |     |     |     |     |     |
| 15                                    | Program/Site Square Footage (OASAS, OPWDD and SED Only) | 00150      |     |     |     |     |     |

Funding State Agency:

- OMH     SED  
 OPWDD     DOH  
 OASAS     OCFS

**NEW YORK STATE**  
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**SCHEDULE CFR-1**  
**PROGRAM/SITE**  
**DATA**

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

| Line No.                                   | COLUMN NUMBER   | Cost  |     |     |     |     |     |
|--|---|-------|-----|-----|-----|-----|-----|
|  | ITEM DESCRIPTION  | Codes |     |     |     |     |     |
|  | Program Code (Program Code Index)                             | 00010 | ( ) | ( ) | ( ) | ( ) | ( ) |
|  | Program/Site Identification Number                            | 00050 |     |     |     |     |     |
| <b>SECTION B: EXPENSES</b>                 |   |       |     |     |     |     |     |
| <b>PERSONAL SERVICES</b>                   |   |       |     |     |     |     |     |
| 16   | Personal Services - Program/Site & Program Admin (from CFR-4) | 11999 |     |     |     |     |     |
| 17   | Vacation Accruals - Program/Site & Program Admin              | 12999 |     |     |     |     |     |
| <b>FRINGE BENEFITS</b>                     |   |       |     |     |     |     |     |
| 18   | Mandated Fringe Benefits                                      | 13200 |     |     |     |     |     |
| 19   | Non-Mandated Fringe Benefits                                  | 13300 |     |     |     |     |     |
| 20   | Total Fringe Benefits (Sum Lines 18 & 19)                     | 13999 |     |     |     |     |     |
| <b>OTHER THAN PERSONAL SERVICES (OTPS)</b> |   |       |     |     |     |     |     |
| 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 (OPWDD and SED only)              | 14070 |     |     |     |     |     |
| 28   | Expensed Equipment  | 14080 |     |     |     |     |     |
| 29   | Sub-Contract Raw Materials                                    | 14090 |     |     |     |     |     |
| 30   | Participant Wages-Non-Contract                                | 14100 |     |     |     |     |     |

Funding State Agency:

- OMH     SED  
 OPWDD     DOH  
 OASAS     OCFS

**NEW YORK STATE**  
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*For the Period: July 1, 2020 to June 30, 2021*

**SCHEDULE CFR-1**  
**PROGRAM/SITE**  
**DATA**

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**AGENCY NAME:** \_\_\_\_\_  
**AGENCY CODE:** \_\_\_\_\_  
**SCHOOL CODE: (SED ONLY)** \_\_\_\_\_

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

- Funding State Agency:
- OMH     SED  
 OPWDD     DOH  
 OASAS     OCFS

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**SCHEDULE CFR-1**  
**PROGRAM/SITE**  
**DATA**

| <b>AGENCY NAME:</b> _____            |  |              |     |     |     |     |
|--------------------------------------|--|--------------|-----|-----|-----|-----|
| <b>AGENCY CODE:</b> _____            |  |              |     |     |     |     |
| <b>SCHOOL CODE: (SED ONLY)</b> _____ |  |              |     |     |     |     |
| Line No.                             | COLUMN NUMBER<br>ITEM DESCRIPTION  | Cost Codes   |     |     |     |     |
|                                      | <b>Program Code (Program Code Index)</b>   | <b>00010</b> | ( ) | ( ) | ( ) | ( ) |
|                                      | <b>Program/Site Identification Number</b>  | <b>00050</b> |     |     |     |     |
| <b>53</b>                            | Mortgage/Capital Improvements Interest (Report MCFFA/DASNY Bond Int. on Line 59) | <b>16060</b> |     |     |     |     |
| <b>54</b>                            | Mortgage Expenses  | <b>16070</b> |     |     |     |     |
| <b>55</b>                            | Insurance-Property & Casualty  | <b>16080</b> |     |     |     |     |
| <b>56</b>                            | Real Estate Taxes  | <b>16090</b> |     |     |     |     |
| <b>57</b>                            | Interest on Capital Indebtedness   | <b>16100</b> |     |     |     |     |
| <b>58</b>                            | Start-up Expenses  | <b>16110</b> |     |     |     |     |
| <b>59</b>                            | MCFFA/DASNY Interest Expense   | <b>16120</b> |     |     |     |     |
| <b>60</b>                            | MCFFA/DASNY Administration Fees  | <b>16130</b> |     |     |     |     |
| <b>61</b>                            | Maintenance in Lieu of Rent (LGU only)   | <b>16140</b> |     |     |     |     |
| <b>62</b>                            | Other (Detail Required)  | <b>16998</b> |     |     |     |     |
| <b>63</b>                            | Total Property-Provider Paid (Sum of Lines 49-62)                                | <b>16999</b> |     |     |     |     |
| <b>TOTALS</b>                        |  |              |     |     |     |     |
| <b>64</b>                            | Total Operating Costs (Sum lines 16, 17, 20, 41 minus 29)                        | <b>19010</b> |     |     |     |     |
| <b>65</b>                            | Agency Admin. Alloc.(Line 64 times _____)*                                       | <b>19050</b> |     |     |     |     |
| <b>66</b>                            | Adjustments/Non-Allowable Costs (Detail Required)                                | <b>19030</b> |     |     |     |     |
| <b>67</b>                            | Total Prog/Site Costs (Sum lines 29, 48, 63-65 minus 66)                         | <b>19060</b> |     |     |     |     |
| <b>OPWDD Only - Informational</b>    |  |              |     |     |     |     |
| <b>68a</b>                           | Other Than To/From Transportation Allocation                                     | <b>19101</b> |     |     |     |     |
| <b>68b</b>                           | To/From Transportation Allocation  | <b>19102</b> |     |     |     |     |
| <b>68c</b>                           | ICF/IID SED Contract Liability   | <b>19103</b> |     |     |     |     |
| <b>68d</b>                           | Program Administration Property  | <b>19104</b> |     |     |     |     |
| <b>68e</b>                           | ICF/IID Day Services Liability   | <b>19105</b> |     |     |     |     |

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

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

| Line No. | COLUMN NUMBER<br>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 |  |  |  |  |  |
| 72a | Medicaid Fee for Service                           | 20045 |  |  |  |  |  |
| 72b | Medicaid Managed Care                              | 20050 |  |  |  |  |  |
| 73  | Medicare   | 20060 |  |  |  |  |  |
| 74  | Other Third Parties                                | 20070 |  |  |  |  |  |
| 75  | OPWDD Residential Room and Board                   | 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 OPWDD only)             | 22080 |  |  |  |  |  |
| 82  | SNAP (OASAS, OPWDD)/Food Revenue (SED Only)        | 22160 |  |  |  |  |  |
| 83  | Gifts, Legacies, Bequests, Donations               | 22010 |  |  |  |  |  |
| 84  | Section 202/8/811 HUD Funds                        | 22020 |  |  |  |  |  |
| 85  | Interest/Dividend Income                           | 22050 |  |  |  |  |  |
| 86  | Prior Period Rate Adjustments*                     | 22090 |  |  |  |  |  |
| 87  | Non-Disabled Universal Pre-Kindergarten (SED Only) | 22100 |  |  |  |  |  |
| 88  | LDSS County Revenue (SED only)                     | 22110 |  |  |  |  |  |
| 89  | 4402 Revenue (School District In-State) (SED only) | 22120 |  |  |  |  |  |

\* Refer to CFR Manual for specific instructions.

Funding State Agency:  
 OMH     SED  
 OPWDD     DOH  
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**DATA**

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

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

\* Do not include non-funded or voluntary contributions.  
 \*\* Amounts should equal the corresponding amounts reported as revenue on line 93 above.

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**SCHEDULE CFR-2**  
**AGENCY FISCAL**  
**SUMMARY**

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|   |  |
|---|--|
| AGENCY NAME: _____<br>AGENCY CODE: _____<br>SCHOOL CODE: (SED ONLY) _____ | <b>THE RECONCILIATION SCHEDULE MUST BE COMPLETED WHEN:</b><br>(1) the expenses and revenues in the CFR do not equal the expenses and revenues in the audited financial statements and<br>(2) the reporting periods of the CFR and financial statements coincide. |
|---|--|

| Line No.        | COLUMN NUMBER<br>ITEM DESCRIPTION           | Cost Codes | 1                               | 2            | 3          | 4            | 5          | 6          | 7           | 8                     | 9                      |
|-----------------|---|------------|---------------------------------|--------------|------------|--------------|------------|------------|-------------|-----------------------|------------------------|
|                 |   |            | AGENCY TOTALS<br>(Sum Col. 2-9) | OASAS TOTALS | OMH TOTALS | OPWDD TOTALS | SED TOTALS | DOH TOTALS | OCFS TOTALS | SHARED PROGRAM TOTALS | 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      |                                 |              |            |              |            |            |             |                       |                        |
| <b>REVENUES</b> |   |            |                                 |              |            |              |            |            |             |                       |                        |
| 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.

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**SCHEDULE CFR-2A**  
**AGENCY**  
**FISCAL DATA**

|                           |                                      |
|---------------------------|--------------------------------------|
| <b>AGENCY NAME:</b> _____ | <b>SCHOOL CODE: (SED ONLY)</b> _____ |
| <b>AGENCY CODE:</b> _____ | <b>TYPE OF OWNERSHIP:</b> _____      |

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**

- 1 Year End Date of Financial Statements
- 2 CPA or Audit Firm (skip if statements are not audited or reviewed)
- 3 Opinion -- use drop-down (skip if statements are not audited)  This is a drop-down with the following selections:  
 Unmodified, Qualified, Disclaimer, Adverse
  
- 4 Type of Financial Statements  This is a drop-down with the following selections:  
 Consolidated, Combined, Consolidated and Combined, Single Entity

**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

|   | Total                                      | Without Donor Restrictions                 | With Donor Restrictions                    |
|---|--|--|--|
| 19 Net Assets/Stockholder's Equity, Beginning of the Year   | <input style="width: 100px;" type="text"/> | <input style="width: 100px;" type="text"/> | <input style="width: 100px;" type="text"/> |
| 20 Change in Net Assets /Net income or Net Deficit/Net Loss | <input style="width: 100px;" type="text"/> | <input style="width: 100px;" type="text"/> | <input style="width: 100px;" type="text"/> |
| 21 Other Changes in Net Assets/Other Comprehensive Income   | <input style="width: 100px;" type="text"/> | <input style="width: 100px;" type="text"/> | <input style="width: 100px;" type="text"/> |
| 22 Net Assets/Stockholder's Equity, End of the Year         | <input style="width: 100px;" type="text"/> | <input style="width: 100px;" type="text"/> | <input style="width: 100px;" type="text"/> |

**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
  
- 28 Operating Transactions
  - A. Operating Revenues and Operating Gains
  - B. Operating Expenses and Operating Losses

**Section D - Line of Credit & Debt**

|                                | Total                                      | Line of Credit 1                           | Line of Credit 2                           | All Other Lines of Credit                  |
|--------------------------------|--|--|--|--|
| <b>Operating Capital</b>       |  |  |  |  |
| 29 Maximum Borrowing Potential | <input style="width: 100px;" type="text"/> |
| 30 Loan Balance at Year End    | <input style="width: 100px;" type="text"/> |
| 31 Interest Rate at Year End   | <input style="width: 100px;" type="text"/> |

- 32 In the current reporting period, has your agency:
 

|   |  |
|---|--|
| <b>Yes</b>  | <b>No</b>                                  |
| A. Refinanced or restructured debt in order to extend the term of the repayment schedule? | <input style="width: 100px;" type="text"/> |
| B. Converted short-term debt into long-term debt?   | <input style="width: 100px;" type="text"/> |

- 33 **Debt Management**

|  |  |
|--|--|
| <b>Yes</b>   | <b>No</b>                                  |
| A. Is the agency in compliance with all debt covenants with their lender(s) on their lines of credit/debt? | <input style="width: 100px;" type="text"/> |
| B. If 33A is "No", did the agency get a waiver from the creditor?  | <input style="width: 100px;" type="text"/> |

- 34 **Going Concern**

|   |  |
|---|--|
| <b>Yes</b>  | <b>No</b>                                  |
| In the audited financial statements, was there substantial doubt raised about your entity's ability to continue as a going concern? | <input style="width: 100px;" type="text"/> |

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**SCHEDULE CFR-3**  
**AGENCY**  
**ADMINISTRATION**

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|                           |                                      |
|---------------------------|--------------------------------------|
| <b>AGENCY NAME:</b> _____ | <b>SCHOOL CODE: (SED ONLY)</b> _____ |
| <b>AGENCY CODE:</b> _____ |                                      |

| Line No.                                   | ITEM DESCRIPTION                                    | COST CODES | AGENCY ADMIN TOTALS |
|--|---|------------|---------------------|
| <b>PERSONAL SERVICES</b>                   |   |            |                     |
| 1  | Total Personal Services (from CFR-4, Agency Admin.) | 11998      |                     |
| 2  | Vacation Leave Accruals                             | 12998      |                     |
| <b>FRINGE BENEFITS</b>                     |   |            |                     |
| 3  | Mandated Fringe Benefits                            | 13201      |                     |
| 4  | Non-Mandated Fringe Benefits                        | 13301      |                     |
| 5  | Total Fringe Benefits (Sum Lines 3 - 4)             | 13998      |                     |
| <b>OTHER THAN PERSONAL SERVICES (OTPS)</b> |   |            |                     |
| 6  | Audit/Legal/Accounting                              | 14200      |                     |
| 7  | Utilities   | 14210      |                     |
| 8  | Telephone, Cable and Internet                       | 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      |                     |
| <b>EQUIPMENT-PROVIDER PAID</b>             |   |            |                     |
| 19   | Lease/Rental-Vehicle                                | 15011      |                     |
| 20   | Lease/Rental-Equipment                              | 15030      |                     |

| Line No.                                   | ITEM DESCRIPTION   | COST CODES | AGENCY ADMIN TOTALS |
|--|--|------------|---------------------|
| <b>EQUIPMENT-PROVIDER PAID (CONTINUED)</b> |  |            |                     |
| 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      |                     |
| <b>PROPERTY-PROVIDER PAID</b>              |  |            |                     |
| 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 (Detail Required)            | 19031      |                     |
| 42   | Net Agency Administration (Line 40 minus 41)                 | 19998      |                     |

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**SCHEDULE CFR-3**  
**AGENCY**  
**ADMINISTRATION**

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|                           |                                      |
|---------------------------|--------------------------------------|
| <b>AGENCY NAME:</b> _____ | <b>SCHOOL CODE: (SED ONLY)</b> _____ |
| <b>AGENCY CODE:</b> _____ |                                      |

| RATIO VALUE WORKSHEET (AGENCY-WIDE)                              |   |            |        |
|--|---|------------|--------|
| Line No.   | State Agency                                    | Cost Codes | Amount |
| <b>CALCULATION OF OPERATING COSTS *</b>                          |   |            |        |
| 43   | OASAS Subtotal                                  | 19110      |        |
| 44   | OMH Subtotal                                    | 19120      |        |
| 45   | OPWDD Subtotal                                  | 19130      |        |
| 46   | SED Subtotal                                    | 19140      |        |
| 47   | DOH Subtotal                                    | 19141      |        |
| 48   | OCFS Subtotal                                   | 19142      |        |
| 49   | Shared Programs Subtotal                        | 19150      |        |
| 50   | Other Programs Subtotal**                       | 19160      |        |
| 51   | Total Agency Operating Costs                    | 19170      |        |
| <b>CALCULATION OF RATIO VALUE FACTOR</b>                         |   |            |        |
| 52   | Net Agency Administration (CFR-3, Line 42)      | 19999      |        |
| 53   | Total Agency Operating Costs (CFR-3, Line 51)   | 19171      |        |
| 54   | Ratio Value Factor (line 52 divided by line 53) | 19180      |        |
| <b>ALLOCATION OF AGENCY ADMINISTRATION USING RATIO VALUE ***</b> |   |            |        |
| 55   | OASAS Allocation (line 43 x line 54)            | 19210      |        |
| 56   | OMH Allocation (line 44 x line 54)              | 19220      |        |
| 57   | OPWDD Allocation (line 45 x line 54)            | 19230      |        |
| 58   | SED Allocation (line 46 x line 54)              | 19240      |        |
| 59   | DOH Allocation (line 47 x line 54)              | 19241      |        |
| 60   | OCFS Allocation (line 48 x line 54)             | 19242      |        |
| 61   | Shared Programs Allocation (line 49 x line 54)  | 19250      |        |
| 62   | Other Programs Allocation (line 50 x line 54)   | 19260      |        |
| 63   | Total Agency Administration (sum lines 55 - 62) | 19270      |        |

| ADJUSTED RATIO VALUE WORKSHEET (WITHIN STATE AGENCY)    |   |            |        |
|---|---|------------|--------|
| Line No.  | State Agency  | Cost Codes | Amount |
| <b>CALCULATION OF ADJUSTED OPERATING COSTS ****</b>     |   |            |        |
| 64  | OASAS Adjusted Subtotal   | 19310      |        |
| 65  | OMH Adjusted Subtotal   | 19320      |        |
| 66  | OPWDD Adjusted Subtotal   | 19330      |        |
| 67  | SED Adjusted Subtotal   | 19340      |        |
| 68  | DOH Adjusted Subtotal   | 19341      |        |
| 69  | OCFS Adjusted Subtotal  | 19342      |        |
| 70  | Shared Programs Adjusted Subtotal                               | 19350      |        |
| <b>CALCULATION OF ADJUSTED RATIO VALUE FACTOR *****</b> |   |            |        |
| 71  | OASAS Ratio Value Factor (line 55 divided by line 64)           | 19410      |        |
| 72  | OMH Ratio Value Factor (line 56 divided by line 65)             | 19420      |        |
| 73  | OPWDD Ratio Value Factor (line 57 divided by line 66)           | 19430      |        |
| 74  | SED Ratio Value Factor (line 58 divided by line 67)             | 19440      |        |
| 75  | DOH Ratio Value Factor (line 59 divided by line 68)             | 19441      |        |
| 76  | OCFS Ratio Value Factor (line 60 divided by line 69)            | 19442      |        |
| 77  | Shared Programs Ratio Value Factor (line 61 divided by line 70) | 19450      |        |

\* Totals by State Agency from CFR-1, Line 64. Do not report operating costs for programs 0880 and 0890.

\*\* This amount must equal the sum of lines 1 through 4 of column 9 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 0880 and 0890 and programs which are exempt from agency administration. For OMH (line 65), do not include operating costs for programs 0860, 0870, 0920, 1230, 1690, 1910, 2740, 2850, 2860, 2980, 6910, 6920, 8810 and programs with an "A" program code index (startup). For OPWDD (line 66), do not include operating costs for program 0190.

\*\*\*\*\* 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.





**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
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**SCHEDULE CFR-5**  
**TRANSACTIONS WITH RELATED**  
**ORGANIZATIONS/INDIVIDUALS**

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|                    |                    |                               |
|--------------------|--------------------|-------------------------------|
| AGENCY NAME: _____ | AGENCY CODE: _____ | SCHOOL CODE: (SED ONLY) _____ |
|--------------------|--------------------|-------------------------------|

**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:

| 1        | 2        | 3   | 4                             | 5  | 6                               | 7                                    | 8                  | 9   |
|----------|----------|---|-------------------------------|--|---------------------------------|--------------------------------------|--------------------|---|
| Line No. | Item No. | PROGRAM/SITES AFFECTED<br>ENTER PROG/SITE ID# (CODE)<br>OR ADMINISTRATION | DESCRIPTION OF<br>TRANSACTION | NAME OF RELATED<br>ORGANIZATION/INDIVIDUAL | RELATIONSHIP<br>TO<br>PROVIDER* | AMOUNT OF<br>TRANSACTION<br>REPORTED | ALLOWABLE<br>COSTS | ADJUSTMENTS<br>TO COSTS<br>(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<br>ENTER PROG/SITE ID# (CODE) OR ADMIN. | DEPRECIATION | MORTGAGE<br>INTEREST | INSURANCE | PROPERTY<br>TAXES | OTHER<br>(SPECIFY) | TOTAL ALLOWABLE<br>COSTS |
| 1        |          |  |              |                      |           |                   |                    |                          |
| 2        |          |  |              |                      |           |                   |                    |                          |
| 3        |          |  |              |                      |           |                   |                    |                          |
| 4        |          |  |              |                      |           |                   |                    |                          |
| 5        |          |  |              |                      |           |                   |                    |                          |

**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.

| 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"/> |                        |

**NEW YORK STATE**  
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**SCHEDULE CFR-6**  
**GOVERNING BOARD AND**  
**COMPENSATION SUMMARY**

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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)         | (2)                          | (3)                | (4)        | (5)                      | (6)                              | (7)   | (8)                    | (9)                      |
|----|-------------|------------------------------|--------------------|------------|--------------------------|----------------------------------|---|------------------------|--------------------------|
|    | <u>NAME</u> | <u>POSITION TITLE CODE *</u> | <u>AMOUNT PAID</u> | <u>FTE</u> | <u>ANNUALIZED SALARY</u> | <u>CONTRACTED PAYMENT AMOUNT</u> | <u>TOTAL ANNUALIZED SALARY AND CONTRACTED PAYMENT</u> | <u>FRINGE BENEFITS</u> | <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)         | (2)                    | (3)                |
|----|-------------|------------------------|--------------------|
|    | <u>NAME</u> | <u>TYPE OF SERVICE</u> | <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**  
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**SCHEDULE DMH-1**  
**PROGRAM FISCAL**  
**SUMMARY**

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

| Line No.                | COLUMN NUMBER<br>ITEM DESCRIPTION             | Cost Codes |     |     |     |     |     |
|-------------------------|---|------------|-----|-----|-----|-----|-----|
| 1                       | Program Type                                  | 00071      |     |     |     |     |     |
| 2                       | Program Code (Program Code Index)             | 00011      | ( ) | ( ) | ( ) | ( ) | ( ) |
| <b>UNITS OF SERVICE</b> |   |            |     |     |     |     |     |
| 3                       | OMH Units of Service                          | 00121      |     |     |     |     |     |
| 4                       | OPWDD Units of Service                        | 00161      |     |     |     |     |     |
| 5                       | OASAS Units of Service                        | 00170      |     |     |     |     |     |
| <b>EXPENSES*</b>        |   |            |     |     |     |     |     |
| 6                       | Personal Services                             | 17010      |     |     |     |     |     |
| 7                       | Vacation Leave Accruals                       | 17020      |     |     |     |     |     |
| 8                       | Fringe Benefits                               | 17030      |     |     |     |     |     |
| 9                       | Other Than Personal Services                  | 17040      |     |     |     |     |     |
| 10                      | Equipment-Provider Paid                       | 17050      |     |     |     |     |     |
| 11                      | Property-Provider Paid                        | 17060      |     |     |     |     |     |
| 12                      | Agency Administration                         | 17080      |     |     |     |     |     |
| 13                      | Adjustments/Non-Allowable Costs               | 17090      |     |     |     |     |     |
| 14                      | Total Adjusted Expenses (Lines 6-12 minus 13) | 17999      |     |     |     |     |     |
| <b>REVENUES*</b>        |   |            |     |     |     |     |     |
| 15                      | Participant Fees (less SSI & SSA)             | 26010      |     |     |     |     |     |
| 16                      | SSI & SSA                                     | 26020      |     |     |     |     |     |
| 17                      | Home Relief/Public Assistance                 | 26030      |     |     |     |     |     |
| 18a                     | Medicaid Fee for Service                      | 26045      |     |     |     |     |     |
| 18b                     | Medicaid Managed Care                         | 26050      |     |     |     |     |     |
| 19                      | Medicare                                      | 26060      |     |     |     |     |     |
| 20                      | Other Third Parties                           | 26070      |     |     |     |     |     |
| 21                      | OPWDD Residential Room and Board              | 26080      |     |     |     |     |     |
| 22                      | Transportation, Medicaid                      | 26090      |     |     |     |     |     |
| 23                      | Transportation, Other                         | 26100      |     |     |     |     |     |
| 24                      | Sales: Contract Total                         | 26140      |     |     |     |     |     |
| 25                      | Federal Grants (Detail Required)              | 26160      |     |     |     |     |     |

\* 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.

Funding State Agency:

- OMH
- OPWDD
- OASAS

**NEW YORK STATE**  
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**SCHEDULE DMH-1**  
**PROGRAM FISCAL**  
**SUMMARY**

Page \_\_\_\_\_

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

| Line | COLUMN NUMBER                                   | Cost  |     |     |     |     |     |
|------|---|-------|-----|-----|-----|-----|-----|
| No.  | ITEM DESCRIPTION                                | Codes |     |     |     |     |     |
|      | Program Type                                    | 00071 |     |     |     |     |     |
|      | Program Code (Program Code Index)               | 00011 | ( ) | ( ) | ( ) | ( ) | ( ) |
| 26   | State Grants (Detail Required)                  | 26190 |     |     |     |     |     |
| 27   | LTSE Income Total (OMH and OPWDD only)          | 26220 |     |     |     |     |     |
| 28   | SNAP (OASAS and OPWDD Only)                     | 26240 |     |     |     |     |     |
| 29   | Net Deficit Funding (State & LGU Funding only)* | 26110 |     |     |     |     |     |
| 30   | Other (Detail Required)                         | 26230 |     |     |     |     |     |
| 31   | Total Gross Revenues (Sum Lines 15-30)          | 26999 |     |     |     |     |     |
|      | <b>GAAP ADJUSTMENTS TO REVENUE**</b>            |       |     |     |     |     |     |
| 32   | Participant Allowance                           | 27010 |     |     |     |     |     |
| 33   | Provision for Bad Debt - Revenue Deduction      | 27040 |     |     |     |     |     |
| 34   | Other (Detail Required)                         | 27045 |     |     |     |     |     |
| 35   | Total GAAP Adjustments (Sum Lines 32-34)        | 27049 |     |     |     |     |     |
| 36   | Net GAAP Revenues (Line 31 minus 35)            | 27025 |     |     |     |     |     |
|      | <b>NON-GAAP ADJUSTMENTS TO REVENUE**</b>        |       |     |     |     |     |     |
| 37   | Exempt Contract Income                          | 27050 |     |     |     |     |     |
| 38   | Exempt LTSE Income                              | 27060 |     |     |     |     |     |
| 39   | Net Deficit Funding***                          | 27070 |     |     |     |     |     |
| 40   | Other (Detail Required)                         | 27080 |     |     |     |     |     |
| 41   | Total NON-GAAP Adjustments (Sum Lines 37-40)    | 27998 |     |     |     |     |     |
| 42   | Subtotal Adj. to Revenue (Sum Lines 35 & 41)    | 27999 |     |     |     |     |     |
| 43   | Total Net Revenues (Line 31 minus 42)           | 28999 |     |     |     |     |     |
| 44   | Net Operating Cost (Line 14 minus 43)           | 29999 |     |     |     |     |     |

\* 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.