NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2019 to December 31, 2019

SCHEDULE CFR-i

AGENCY IDENTIFICATION AND CERTIFICATION STATEMENT

AGENCY NAME: _____

AGENCY ADDRESS: _____

_____

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

AGENCY CODE: _____

COUNTY NAME: _____

COUNTY CODE: _____

TYPE OF OWNERSHIP:

NOT-FOR-PROFIT: ☐

PROPRIETARY: ☐

GOVERNMENTAL: ☐

SCHOOL CODE (SED ONLY): __ __ __ __ __ __ __ __ __ __ __ __

FEDERAL EMPLOYER ID NUMBER: _____

CERTIFIED FINANCIAL STATEMENT REPORTING PERIOD: _____

Person to Contact with Regard to Questions Concerning this Report:

_____ ( ) _____

Name **Telephone Number**

_____

Title

_____ ( ) _____

E-mail Address **FAX Number**

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

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

Contact Information for President/Chair, Board of Directors:

_____

Name

_____

Title

_____

E-mail Address

MISREPRESENTATION OF ANY INFORMATION CONTAINED IN THIS REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER NEW YORK STATE LAW.

CERTIFICATION STATEMENT

I HEREBY CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT, THAT THE INFORMATION FURNISHED IN THIS REPORT HAS BEEN COMPLETED IN ITS ENTIRETY, AND IS IN ACCORDANCE WITH THE INSTRUCTIONS AND IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER ATTEST TO THE FACT THAT THERE ARE RECORDS AND ALLOCATION WORKSHEETS TO SUPPORT ALL THE INFORMATION CONTAINED HEREIN, IN THE CUSTODY OF THE ABOVE NAMED SPONSORING AGENCY. I ACKNOWLEDGE THAT THE DEPARTMENT OF MENTAL HYGIENE, OR ANY OF ITS OFFICES OR DIVISIONS, OR THE STATE EDUCATION DEPARTMENT, OR ANY OF ITS OFFICES OR DIVISIONS, MAY REJECT THIS REPORT IF IT HAS NOT BEEN FULLY, OR ACCURATELY COMPLETED.

_____

Date

_____

Name and Title

( )

_____

Telephone Number

_____

E-mail Address

_____

Signature of Chief Executive Officer

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

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2019 to December 31, 2019

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

AGENCY NAME: _____ **AGENCY CODE:** _____ **SCHOOL CODE (SED ONLY):** _____

We have audited the accompanying financial statements of (Agency Name) which comprise the statements of financial position at December 31, 2019, and the related statements of activities, changes in net assets and cash flows for the year then ended and the related notes to the financial statements.

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, 2019, 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: January 1, 2019 to December 31, 2019

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

AGENCY NAME: _____ **AGENCY CODE:** _____ **SCHOOL CODE (SED ONLY):** _____

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, 2019: 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 Alcoholism and Substance Abuse Services, 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, 2019. 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 Alcoholism and Substance Abuse Services, 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, 2019 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, 2019. 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 Alcoholism and Substance Abuse Services, 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, 2019, 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 state

Firm Name

Firm Address

Telephone #

Firm Contact Person

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2019 to December 31, 2019

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

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

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, 2019: Schedules (as applicable) 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 Alcoholism and Substance Abuse Services, 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, 2019. 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 Office of Mental Health, New York State Office of Alcoholism and Substance Abuse Services, 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, 2019 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 judgment, 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, 2019. 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 Alcoholism and Substance Abuse Services, 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, 2019, 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: January 1, 2019 to December 31, 2019

SCHEDULE CFR-iii
COUNTY/NYC
CERTIFICATION
STATEMENT

AGENCY NAME: _____ **AGENCY CODE:** _____

COUNTY/NYC - OPERATED OR VOLUNTARY LOCAL SERVICE PROVIDER CERTIFICATION

I certify that the attached statement fully and accurately represents all reportable income and expenditures made for services performed in accordance with the provision of the Mental Hygiene Law and approved budgets.

There are records and worksheets to support this statement in the custody of the above named agency. Such records and worksheets include the necessary summaries of payrolls and time records, abstracts from ledgers, registers or other expense records. All income from fees, all payments by other State or Federal agencies and any other income have been recorded, included and summarized in support of the amounts reported herein.

Records and worksheets, including records which show that the agency has applied for and received, or received formal notification of refusal of, all forms of third party reimbursement and federal aid, which may be appropriate for such services, are on file at the above location and available for audit by the Office of the State Comptroller and/or representatives of the New York State Commissioner of the Office of Alcoholism and Substance Abuse Services, Commissioner of the Office 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)

Title: _____
(Service Provider's Chief Executive Officer)

Date: _____

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

Title: _____
(LGU's Chief Fiscal Officer)

Date: _____

LOCAL GOVERNMENTAL UNIT CERTIFICATION

I have verified that the costs and revenue reported in the Total column of Schedule DMH-3 are consistent with the contract expenditures and income amounts as approved by this local governmental unit. I also affirm that the expenditures were necessary to provide the services covered by the approved budget and that further review will establish if all income has been fully reported.

I understand that the State Aid paid to this local governmental unit on the basis of this certification may be adjusted, modified and reduced if records are not available, or do not support this financial statement. I hereby recommend that final reimbursement be approved.

Signed: _____
Director of Community Mental Health Services

Local Governmental Unit: _____
Specify

Date: _____

NEW YORK STATE
CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2019 to December 31, 2019

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: January 1, 2019 to December 31, 2019

SCHEDULE CFR-1
PROGRAM/SITE
DATA

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

Line No.	COLUMN NUMBER / ITEM DESCRIPTION	Cost Codes					
SECTION A: GENERAL INFORMATION							
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
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2019 to December 31, 2019

SCHEDULE CFR-1
PROGRAM/SITE
DATA

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

Line No.	COLUMN NUMBER / ITEM DESCRIPTION	Cost Codes					
	Program Code (Program Code Index)	**00010**	( )	( )	( )	( )	( )
	Program/Site Identification Number	**00050**					
SECTION B: EXPENSES							
	PERSONAL SERVICES						
16	Personal Services - Program/Site & Program Admin (from CFR-4)	**11999**					
17	Vacation Accruals - Program/Site & Program Admin	**12999**					
	FRINGE BENEFITS						
18	Mandated Fringe Benefits	**13200**					
19	Non-Mandated Fringe Benefits	**13300**					
20	Total Fringe Benefits (Sum Lines 18 & 19)	**13999**					
	OTHER THAN PERSONAL SERVICES (OTPS)						
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
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2019 to December 31, 2019

SCHEDULE CFR-1
PROGRAM/SITE
DATA

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

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

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

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2019 to December 31, 2019

SCHEDULE CFR-1
PROGRAM/SITE
DATA

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

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

*** 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.**

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

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2019 to December 31, 2019

SCHEDULE CFR-1
PROGRAM/SITE
DATA

AGENCY NAME:_____
AGENCY CODE:_____
SCHOOL CODE: (SED ONLY) __ __ __ __ __ __ __ __ __ __ __ __

Line No.	COLUMN NUMBER / 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
☐ OASAS ☐ OCFS

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2019 to December 31, 2019

SCHEDULE CFR-1
PROGRAM/SITE
DATA

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

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

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

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2019 to December 31, 2019

SCHEDULE CFR-2
AGENCY FISCAL SUMMARY

AGENCY NAME:_____
AGENCY CODE:_____
SCHOOL CODE: (SED ONLY) __ __ __ __ __ __ __ __ __ __ __ __

THE RECONCILIATION SCHEDULE MUST BE COMPLETED WHEN:
(1) the expenses and revenues in the CFR do not equal the expenses and revenues in the audited financial statements and
(2) the reporting periods of the CFR and financial statements coincide.

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

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2019 to December 31, 2019

SCHEDULE CFR-2A
AGENCY
FISCAL DATA

AGENCY NAME: _____ **SCHOOL CODE: (SED ONLY)** _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
AGENCY CODE: _____ **TYPE OF OWNERSHIP:** _____

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			
20	Change in Net Assets /Net income or Net Deficit/Net Loss			
21	Other Changes in Net Assets/Other Comprehensive Income			
22	Net Assets/Stockholder's Equity, End of the Year			

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
	Operating Capital				
29	Maximum Borrowing Potential				
30	Loan Balance at Year End				
31	Interest Rate at Year End				

		Yes	No
32	In the current reporting period, has your agency:		
	A. Refinanced or restructured debt in order to extend the term of the repayment schedule?		
	B. Converted short-term debt into long-term debt?		

		Yes	No
33	**Debt Management**		
	A. Is the agency in compliance with all debt covenants with their lender(s) on their lines of credit/debt?		
	B. If 33A is "No", did the agency get a waiver from the creditor?		

		Yes	No
34	**Going Concern** In the audited financial statements, was there substantial doubt raised about your entity's ability to continue as a going concern?		

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
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SCHEDULE CFR-3
AGENCY ADMINISTRATION

Page _____

AGENCY NAME:_____ **SCHOOL CODE: (SED ONLY)** __ __ __ __ __ __ __ __ __ __ __ __ __
AGENCY CODE:_____

Line No.	ITEM DESCRIPTION	COST CODES	AGENCY ADMIN TOTALS
	PERSONAL SERVICES		
1	Total Personal Services (from CFR-4, Agency Admin.)	11998	
2	Vacation Leave Accruals	12998	
	FRINGE BENEFITS		
3	Mandated Fringe Benefits	13201	
4	Non-Mandated Fringe Benefits	13301	
5	Total Fringe Benefits (Sum Lines 3 - 4)	13998	
	OTHER THAN PERSONAL SERVICES (OTPS)		
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	
	EQUIPMENT-PROVIDER PAID		
19	Lease/Rental-Vehicle	15011	
20	Lease/Rental-Equipment	15030	

Line No.	ITEM DESCRIPTION	COST CODES	AGENCY ADMIN TOTALS
	EQUIPMENT-PROVIDER PAID (CONTINUED)		
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	
	PROPERTY-PROVIDER PAID		
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	

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2019 to December 31, 2019

SCHEDULE CFR-3
AGENCY ADMINISTRATION

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

AGENCY CODE:_____

RATIO VALUE WORKSHEET (AGENCY-WIDE)

Line No.	State Agency	Cost Codes	Amount
CALCULATION OF OPERATING COSTS *			
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**	
CALCULATION OF RATIO VALUE FACTOR			
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**	
ALLOCATION OF AGENCY ADMINISTRATION USING RATIO VALUE *			
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
CALCULATION OF ADJUSTED OPERATING COSTS **			
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**	
CALCULATION OF ADJUSTED RATIO VALUE FACTOR ***			
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 7 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.**

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

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
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SCHEDULE CFR-4
PERSONAL SERVICES

Page _____

AGENCY NAME:_____
AGENCY CODE:_____
SCHOOL CODE: (SED ONLY) __ __ __ __ __ __ __ __ __ __ __ __

FTE'S MUST BE CALCULATED TO 3 DECIMAL PLACES.

Provide all applicable information. Refer to Appendix R for Position Title Codes and Definitions. Indicate the standard work week or provide the number of hours in the "other" column.
Indicate the applicable staffing category on the line below to which each page applies.

PROGRAM/SITE-PROGRAM ADMIN./LGU ADMIN. (Position Title Codes 100-599 and 700-799 series) ____ **AGENCY ADMINISTRATION (Position Title Codes 600-699 series) ____***

Position Title Code Appendix R	COLUMN NUMBER																			
	PROGRAM CODE ** (PROGRAM CODE INDEX)					( )			( )			( )			( )			( )		
	PROGRAM/SITE IDENTIFICATION NUMBER **																			
	PROGRAM/SITE NAME																			
	PROGRAM/SITE ADDRESS (Line One)																			
	PROGRAM/SITE ADDRESS (Line Two)																			
	COUNTY CODE																			
	Position Title	Standard Work Week				Hours Paid	FTE	Amount Paid	Hours Paid	FTE	Amount Paid	Hours Paid	FTE	Amount Paid	Hours Paid	FTE	Amount Paid	Hours Paid	FTE	Amount Paid
		35	37.5	40	Other															
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.

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

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2019 to December 31, 2019

SCHEDULE CFR-4A
CONTRACTED DIRECT CARE AND CLINICAL PERSONAL SERVICES

AGENCY NAME:_____
AGENCY CODE:_____
SCHOOL CODE: (SED ONLY) __ __ __ __ __ __ __ __ __ __ __ __

Refer to Appendix R for Position Title Codes and definitions.
Report only program/site specific positions (Position Title Codes 200-399 series).

Position Title Code Appendix R	COLUMN NUMBER										
	PROGRAM CODE (PROGRAM CODE INDEX)	( )		( )		( )		( )		( )	
	PROGRAM/SITE IDENTIFICATION NUMBER										
	PROGRAM/SITE NAME										
	PROGRAM/SITE ADDRESS (Line One)										
	PROGRAM/SITE ADDRESS (Line Two)										
	COUNTY CODE										
	Position Title	Hours Paid	Amount Paid	Hours Paid	Amount Paid	Hours Paid	Amount Paid	Hours Paid	Amount Paid	Hours Paid	Amount Paid
Total "Hours Paid" and "Amount Paid" for Positions.											

Totals are transferred to Schedule CFR-1 Line 35 (Program/Site).

NEW YORK STATE

CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2019 to December 31, 2019

SCHEDULE CFR-5
TRANSACTIONS WITH RELATED ORGANIZATIONS/INDIVIDUALS

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 ENTER PROG/SITE ID# (CODE) OR ADMINISTRATION	DESCRIPTION OF TRANSACTION	NAME OF RELATED ORGANIZATION/INDIVIDUAL	RELATIONSHIP TO PROVIDER*	AMOUNT OF TRANSACTION REPORTED	ALLOWABLE COSTS	ADJUSTMENTS TO COSTS (COL. 7 MINUS 8)
1								
2								
3								
4								
5								

SECTION C: For space lease/rental agreements listed in section B above, detail the related organization's/individual's allowable costs reported in section B, Allowable Costs column:

1	2	3	4	5	6	7	8	9
Line No.	Item No.	PROGRAM/SITES AFFECTED ENTER PROG/SITE ID# (CODE) OR ADMIN.	DEPRECIATION	MORTGAGE INTEREST	INSURANCE	PROPERTY TAXES	OTHER (SPECIFY)	TOTAL ALLOWABLE COSTS
1								
2								
3								
4								
5								

SECTION D: (This section applies only to OASAS, OMH, 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
Line No.	Item No.	Name of Related Party/Individual	Street Address	City, State	Type of Financial Support/Aid	Funding To	Funding From	Funding To/From Amount
1						☐	☐	
2						☐	☐	
3						☐	☐	
4						☐	☐	
5						☐	☐	

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2019 to December 31, 2019

SCHEDULE CFR-6
GOVERNING BOARD AND
COMPENSATION SUMMARY

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:

	NAME	AMOUNT PAID	CONTRACTED PAYMENT AMOUNT	FRINGE BENEFITS	OTHER BENEFITS **	TOTAL COMPENSATION
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) NAME	(2) POSITION TITLE CODE *	(3) AMOUNT PAID	(4) FTE	(5) ANNUALIZED SALARY	(6) CONTRACTED PAYMENT AMOUNT	(7) TOTAL ANNUALIZED SALARY AND CONTRACTED PAYMENT	(8) FRINGE BENEFITS	(9) OTHER BENEFITS **
A.		☐							
B.		☐							
C.		☐							
D.		☐							
E.		☐							

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

	(1) NAME	(2) TYPE OF SERVICE	(3) AMOUNT PAID
A.			
B.			
C.			
D.			
E.			

* **If an individual is reported under more than one position title code on CFR-4, please check the box in column 2.**

** **Cash value of awards, rewards, loans or other benefits made in lieu of, or in addition to, monetary compensation or regular fringe benefits.**
Regular fringe benefits are received by all classes or categories of employees. (e.g.: Payroll Taxes, Health Insurance, Pension Costs, Tuition Reimbursement, Severance Benefits)

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

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2019 to December 31, 2019

SCHEDULE DMH-1
PROGRAM FISCAL SUMMARY

AGENCY NAME:_____

AGENCY CODE:_____

Line No.	COLUMN NUMBER / ITEM DESCRIPTION	Cost Codes					
1	Program Type	00071					
2	Program Code (Program Code Index)	00011	( )	( )	( )	( )	( )
	UNITS OF SERVICE						
3	OMH Units of Service	00121					
4	OPWDD Units of Service	00161					
5	OASAS Units of Service	00170					
	EXPENSES*						
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					
	REVENUES*						
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
CONSOLIDATED FISCAL REPORT
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SCHEDULE DMH-1
PROGRAM FISCAL SUMMARY

AGENCY NAME:_____

AGENCY CODE:_____

Line No.	COLUMN NUMBER / ITEM DESCRIPTION	Cost 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					
	GAAP ADJUSTMENTS TO REVENUE**						
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					
	NON-GAAP ADJUSTMENTS TO REVENUE**						
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.