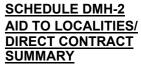
Funding State Agency:

□ OMH □ OPWDD □ OASAS

NEW YORK STATE

CONSOLIDATED FISCAL REPORT For the Period: July 1, 2019 to June 30, 2020



| AGENCY NAME: | PREPARED E | BY: | | | | | TELEPHONE: (|) |
|---|--------------|---------------------------|------------|-----------------|-----------------|-------|--------------|-----|
| AGENCY CODE: | □ Please che | eck the box if the prepar | er changed | from the previo | ous submission. | | | |
| COUNTY NAME & CODE:(|) | | | P | LEASE CHECK: | FINAL | | |
| Line COLUMN NUMBER | Cost | | | | | | | |
| No. ITEM DESCRIPTION | Codes | | | | | | | |
| 1 Accounting Method | | | | | | | | |
| 2 State Contract Number / LGU Contract Number * | 00200 | | | | | | | |
| 3 Program Type | 00072 | | | | | | | |
| 4 Program Code (Program Code Index) | 00012 | (|) | (|) | () | () | () |
| EXPENSES | | | _ | | | | | |
| 5 Personal Services | 18010 | | | | | | | |
| 6 Vacation Leave Accruals ** | 18020 | | | | | | | |
| 7 Fringe Benefits | 18030 | | | | | | | |
| 8 Other Than Personal Services (OTPS) | 18040 | | | | | | | |
| 9 Equipment-Provider Paid *** | 18050 | | | | | | | |
| 10 Property-Provider Paid **** | 18060 | | | | | | | |
| 11 Agency Administration | 18080 | | | | | | | |
| 12 Adjustments/Non-Allowable Costs (Detail Required | d) 18090 | | | | | | | |
| 13 Total Adjusted Expenses (Lines 5-11 minus 12) | 18999 | | | | | | | |
| REVENUES | | | | | | | | |
| 14 Participant Fees (less SSI & SSA) | 46010 | | | | | | | |
| 15 SSI & SSA | 46020 | | | | | | | |
| 16 Home Relief/Public Assistance | 46030 | | | | | | | |
| 17a Medicaid Fee for Service | 46045 | | | | | | | |
| 17b Medicaid Managed Care | 46050 | | | | | | | |
| 18 Medicare | 46060 | | | | | | | |
| 19 Other Third Parties | 46070 | | | | | | | |
| 20 OPWDD Residential Room and Board | 46080 | | | | | | | |
| 21 Transportation, Medicaid | 46090 | | | | | | | |
| 22 Transportation, Other | 46100 | | | | | | | |
| 23 Sales: Contract Total | 46140 | | | | | | | |
| 24 Federal Grants (Detail Required) | 46160 | | | | | | | |

* For direct contracts, enter the State Contract Number. For local contracts, enter the local Contract Number, if applicable.

** OASAS funded service providers cannot report vacation leave accruals for State aid reimbursement.

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CONSOLIDATED FISCAL REPORT AID TO LOCALITIES/ DIRECT CONTRACT For the Period: July 1, 2019 to June 30, 2020 SUMMARY Page AGENCY NAME: PREPARED BY: TELEPHONE: () \Box Please check the box if the preparer changed from the previous submission. AGENCY CODE: COUNTY NAME & CODE: FINAL CLAIM PLEASE CHECK: ESTIMATED CLAIM COLUMN NUMBER Cost ITEM DESCRIPTION Codes Line No. Program Type 00072 Program Code (Program Code Index) 00012 25 State Grants (Detail Required) 46190 26 LTSE Income Total (OMH and OPWDD Only) 46220 27 SNAP (OASAS and OPWDD Only) 46240 28 Net Deficit Funding (State & LGU Funding Only)* 46110 29 Other (Detail Required) 46230 30 Total Gross Revenue (Sum Lines 14-29) 46999 GAAP ADJUSTMENTS TO REVENUE 31 Participant Allowance 47010 32 Provision for Bad Debt - Revenue Deduction 47040 33 Other (Detail Required) 47045 34 Total GAAP Adjustments (Sum Lines 31-33) 47049 35 Net GAAP Revenues (Line 30 minus 34) 47025 NON-GAAP ADJUSTMENTS TO REVENUE 36 Exempt Contract Income 47050 37 Exempt LTSE Income 47060 38 Net Deficit Funding** 47070 39 Other (Detail Required) 47080 40 Total NON-GAAP Adjustments (Sum Lines 36-39) 47998 41 Subtotal Adj. to Revenue (Sum Lines 34 & 40) 47999 42 Total Net Revenues (Line 30 minus 41) 48999 43 Net Operating Costs (Line 13 minus 42) 49999 DEFICIT FUNDING 44 State Share 60010 45 Local Government Share 60020 46 Service Provider Share (Voluntary Contributions) 60030 47 Total Approved Deficit Funding (Sum lines 44 - 46) 60039 48 Non-Funded 60040 49 Total Net Deficit (Sum Lines 47-48) 60999

* Do not include non-funded or voluntary contributions.

** Amounts should equal the corresponding amounts reported as revenue on line 28 above.

DMH-2.2 Aug. 2020 Rev.

NEW YORK STATE

SCHEDULE DMH-2

| Funding State Agency: | ing State Agency: |
|-----------------------|-------------------|
|-----------------------|-------------------|