NEW YORK STATE

CONSOLIDATED FISCAL REPORT

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

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: _____

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

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.

COMPLETE ONLY
IF THIS REPORT
CONTAINS STATE AID
FUNDED PROGRAMS

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

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 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)

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: July 1, 2019 to June 30, 2020

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:**

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

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		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*
	EXPENSES											
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: July 1, 2019 to June 30, 2020

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
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SCHEDULE CFR-5
TRANSACTIONS WITH RELATED ORGANIZATIONS/INDIVIDUALS

Page _____

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: July 1, 2019 to June 30, 2020

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: July 1, 2019 to June 30, 2020

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

SCHEDULE DMH-1
PROGRAM FISCAL SUMMARY

Page _____

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.

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

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

SCHEDULE DMH-2
AID TO LOCALITIES/
DIRECT CONTRACT
SUMMARY

AGENCY NAME:_____ PREPARED BY: _____ TELEPHONE: (____) _____

AGENCY CODE:_____ ☐ Please check the box if the preparer changed from the previous submission.

COUNTY NAME & CODE: _____(____) PLEASE CHECK: FINAL CLAIM _____

Line No.	COLUMN NUMBER / ITEM DESCRIPTION	Cost Codes					
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)	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.

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

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

SCHEDULE DMH-2
AID TO LOCALITIES/
DIRECT CONTRACT
SUMMARY

AGENCY NAME:_____ PREPARED BY: _____ TELEPHONE: (____) _____

AGENCY CODE:_____ ☐ Please check the box if the preparer changed from the previous submission.

COUNTY NAME & CODE: _____(____) PLEASE CHECK: ESTIMATED CLAIM ____ FINAL CLAIM _____

Line No.	COLUMN NUMBER / ITEM DESCRIPTION	Cost Codes					
	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.

FundingState Agency:
- ☐ OMH
- ☐ OPWDD
- ☐ OASAS

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

SCHEDULE DMH-3
AID TO LOCALITIES AND DIRECT CONTRACTS
PROGRAM FUNDING SOURCE SUMMARY

AGENCY NAME:_____ PREPARED BY: _____ TELEPHONE: (____) _____

AGENCY CODE:_____ ☐ Please check the box if the preparer changed from the previous submission.

COUNTY NAME & CODE: _____(_____) PLEASE CHECK: FINAL CLAIM _____

Line No.	COLUMN NUMBER / ITEM DESCRIPTION		Cost Codes										TOTAL
1	Accounting Method												
2	Program Type		00073										
3	Program Code (Program Code Index)		00013		( )		( )		( )		( )		( )	
4	Total Persons Served/Year		00220										
5	Total Units of Service		00999										
6	Gross Cost/Unit of Service		70999										
7	Net Cost/Unit of Service		71999										
8	Reserved for Future Use		72999										
9	A. Funding Source Code (Local Assistance)	Index (OMH/OASAS only)		001		001		001		001		001	
10	Number Persons Served/Year		00260										
11	Number Units of Service		00250										
12	Total Adjusted Expenses		50999										
13	Less Applied Net Revenue		61999										
14	Net Operating Costs		62999										
15	State Contract Number / LGU Contract Number *		00201										
16	B. Funding Source Code	Index (OMH/OASAS only)											
17	Number Persons Served/Year		00261										
18	Number Units of Service		00251										
19	Total Adjusted Expenses		50998										
20	Less Applied Net Revenue		61998										
21	Net Operating Costs		62998										
22	State Contract Number / LGU Contract Number *		00202										
23	C. Funding Source Code	Index (OMH/OASAS only)											
24	Number Persons Served/Year		00262										
25	Number Units of Service		00252										
26	Total Adjusted Expenses		50997										
27	Less Applied Net Revenue		61997										
28	Net Operating Costs		62997										
29	State Contract Number / LGU Contract Number *		00203										
	D. Totals From A-C Above												
30	Total Adjusted Expenses		51999										
31	Less Net Revenue		63999										
32	Net Operating Costs		52999										

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