NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2004 to December 31, 2004

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 (OMRDD Only): _____

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
☐ OMRDD
☐ OASAS
☐ SED

CHECK THE CFR SUBMISSION TYPE:

☐ FULL CFR
☐ ABBREVIATED CFR
☐ ARTICLE 28 ABBREVIATED CFR
☐ MINI-ABBREVIATED CFR
☐ ESTIMATED CLAIM

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

_____
Signature of Chief Executive Officer

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

PLEASE NUMBER ALL PAGES CONSECUTIVELY. LIST THE TOTAL NUMBER OF PAGES SUBMITTED. _____

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2004 to December 31, 2004

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

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

I/We have audited the accompanying (general purpose) financial statements of the Agency/County listed above, as of December 31, 2004 and for the year then ended. These financial statements and the schedules referred to below are the responsibility of the Agency's/County's management. My/Our responsibility is to express an opinion on these financial statements and the schedules referred to below based on our audit.

I/We conducted such audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that I/we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. I/We believe my/our audit provides a reasonable basis for my/our opinion.

In my/our opinion, the (general purpose) financial statements referred to above present fairly, in all material respects, the financial position of the Agency/County for the year ended as noted in the first paragraph above, and the changes in its net assets and its cash flows, if applicable, for the year then ended, in conformity with accounting principles generally accepted in the United States of America.

My/Our audit was made for the purpose of forming an opinion on the (general purpose) financial statements taken as a whole. The accompanying financial and statistical information included on Schedules (as applicable) CFR-1, lines 13, 16, 17, 20, 41, 48, 63-67, 69-107; CFR-2; CFR-3; CFR-4; CFR-4A; CFR-5; DMH-1; OMRDD-3; OMRDD-4; OMH-1; and SED-1 is presented for purposes of additional analysis and is not a required part of the (general purpose) financial statements. Such accompanying information reported on the CFR with Document Control Number _____ has been subjected to the auditing procedures applied in the audit of the (general purpose) financial statements. My/Our procedures also included those minimum audit procedures, where applicable, set forth in the CFR Audit Guidelines contained in Appendix AA of the Consolidated Fiscal Reporting and Claiming Manual. In my/our opinion, the schedules referred to above are fairly stated, in all material respects, in relation to the (general purpose) financial statements taken as a whole, have been completed in all material respects in accordance with the guidance contained in the Consolidated Fiscal Reporting and Claiming Manual, and for all State Education Department programs, have also been completed in all material respects in conformity with Section 200.9 or Section 200.10 (b), (i), (j), (k) and (l) and Section 175.6 of the Regulations of the Commissioner of Education and the State Education Department's Reimbursable Cost Manual, as applicable.

The other information included in this Consolidated Fiscal Report not detailed in the preceding paragraphs, was not audited by me/us, and accordingly, I/we express no opinion thereon.

This report is intended solely for the information and use of management of the Agency/County, 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.

Date CFR-ii Signed	**Signature of Independent Licensed or Independent Certified Public Accountant or Firm**
***Date of Report** (Enter the date of the audit report on the financial statements, e.g. the date the field work for the audit was completed.)*	**Firm Name**
Telephone Number	**Firm Address**

*** The Auditor has not performed any audit procedures since the date of the Auditor's Report on the financial statements.**

COMPLETE ONLY
IF THIS REPORT
CONTAINS STATE AID
FUNDED PROGRAMS

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2004 to December 31, 2004

SCHEDULE CFR-iii
COUNTY/NYC
CERTIFICATION
STATEMENT

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

Page____

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 of Mental Retardation and 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: _____

Please Check State Agency:
- ☐ OMH ☐ SED
- ☐ OMRDD
- ☐ OASAS

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2004 to December 31, 2004

SCHEDULE CFR-1
PROGRAM/SITE DATA

Page _____

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					
7	Medicaid Provider Agreement Number (DMH only)	00060					
8	County Code (See Appendix C)	00080					
9	Date Site Opened	00090					
10	Certified Capacity (OASAS, OMRDD and SED only)	00100					
11	Actual Capacity (OMH, OMRDD and SED only)	00110					
12	Actual Days Program/Site Open	00160					
13	Units of Service	00120					
14	Respite or TUBS Units of Service (OMRDD only)	00130					
15	Program/Site Square Footage (OASAS and OMRDD only)	00150					

Note: Keep program columns consistent throughout the CFR document.

Please Check State Agency:
- ☐ OMH ☐ SED
- ☐ OMRDD
- ☐ OASAS

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2004 to December 31, 2004

SCHEDULE CFR-1
PROGRAM/SITE DATA

Page _____

AGENCY NAME:_____ USE WHOLE DOLLARS.

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*	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 (OMRDD and SED only)	14070					
28	Expensed Equipment	14080					
29	Sub-Contract Raw Materials	14090					
30	Participant Wages-Non-Contract	14100					

*** Must equal program/site specific totals (Support, Direct Care, Clinical, Production, LGU Admin) and Program Administration totals. Do not include agency administration amounts.**

**** Include only expenses associated with this program/site, not expenses associated with a transportation cost center.**

Note: Keep program columns consistent throughout the CFR document.

Please Check State Agency:
☐ OMH ☐ SED
☐ OMRDD
☐ OASAS

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2004 to December 31, 2004

SCHEDULE CFR-1
PROGRAM/SITE DATA

AGENCY NAME:_____

AGENCY CODE:_____

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

USE WHOLE DOLLARS.

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 (OMRDD 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	**14190**					
39	Insurance - General	**14260**					
40	Other (Attach detail for individual items costing > $1,000)	**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 (Attach detail for individual items costing > $1,000)	**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**					

Note: Keep program columns consistent throughout the CFR document.

Please Check State Agency:
- ☐ OMH ☐ SED
- ☐ OMRDD
- ☐ OASAS

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2004 to December 31, 2004

SCHEDULE CFR-1
PROGRAM/SITE DATA

Page _____

AGENCY NAME:_____ USE WHOLE DOLLARS.

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 (Attach detail for individual items costing > $1,000)	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	19030					
67	Total Prog/Site Costs (Sum lines 29, 48, 63-65 minus 66)	19060					
Transportation Allocation (OMRDD Only - Informational)							
68a	Other Than To/From Transportation Allocation	19101					
68b	To/From Transportation Allocation	19102					

*** Enter the applicable 6 digit adjusted ratio value factor from CFR-3.2, line 65 through 69. Agency administration should not be allocated to programs 0190, 0880, 0890 and state agency specific programs which are exempt from agency administration.**

Note: Keep program columns consistent throughout the CFR document.

Please Check State Agency:
- ☐ OMH ☐ SED
- ☐ OMRDD
- ☐ OASAS

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2004 to December 31, 2004

SCHEDULE CFR-1
PROGRAM/SITE DATA

Page _____

AGENCY NAME:_____

AGENCY CODE:_____

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

USE WHOLE DOLLARS.

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**					
72	Medicaid	**20040**					
73	Medicare	**20060**					
74	Other Third Parties	**20070**					
75	OMRDD Residential Room and Board/NYS OPTS	**20080**					
76	Transportation, Medicaid	**20090**					
77	Transportation, Other (Specify)	**20100**					
78	Sales: Contract Total	**21070**					
79	Federal Grants (Attach detail)	**22040**					
80	State Grants (Attach detail)	**22030**					
81	LTSE Income Total (OMH and OMRDD only)	**22080**					
82	Food Stamps (OASAS Only)/Food Revenue (SED Only)	**22160**					
83	Gifts, Legacies, Bequests, Restricted Donations	**22010**					
84	Section 202/8/811 HUD Funds*	**22020**					
85	Interest/Dividend Income	**22050**					
86	Prior Period Rate Adjustments**	**22090**					
87	VESID Revenue (SED only)	**22100**					
88	LDSS County Revenue (SED only)	**22110**					
89	4402 Revenue (School District In-State) (SED only)	**22120**					

*** For OMRDD programs, if this line is completed, complete Schedule OMRDD-3 (HUD Revenues and Expenses).**

**** Refer to CFR manual for specific instructions.**

Note: Keep program columns consistent throughout the CFR document.

Please Check State Agency:
☐ OMH ☐ SED
☐ OMRDD
☐ OASAS

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2004 to December 31, 2004

SCHEDULE CFR-1
PROGRAM/SITE
DATA

Page _____

AGENCY NAME:_____

AGENCY CODE:_____

SCHOOL CODE: (SED ONLY) _ _ _ _ _ _ _ _ _ _ _ _ _

USE WHOLE DOLLARS.

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 (Attach detail for revenue items > $1,000)	**22998**					
95	Gross Revenues (Sum Lines 69-94)	**23999**					
	GAAP ADJUSTMENTS TO REVENUE						
96	Participant Allowance	**24010**					
97	Uncollectible Accounts Receivable	**24040**					
98	Other (Attach detail for adjustment items > $1,000)	**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 (Attach detail for adjustment items > $1,000)	**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.**
Note: Keep program columns consistent throughout the CFR document.

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2004 to December 31, 2004

SCHEDULE CFR-2
AGENCY FISCAL SUMMARY

Page _____

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

PLEASE PROVIDE A DETAILED RECONCILIATION OF TOTAL EXPENSES AND REVENUES TO THE AGENCY'S AUDITED FINANCIAL STATEMENTS WHEN REPORTING PERIODS COINCIDE. USE WHOLE DOLLARS.

Line No.	COLUMN NUMBER / ITEM DESCRIPTION / EXPENSES		Cost Codes	1 AGENCY TOTALS (Sum Col. 2-7)	2 OASAS TOTALS	3 OMH TOTALS	4 OMRDD TOTALS	5 SED TOTALS	6 SHARED PROGRAM TOTALS	7 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, 2004 to December 31, 2004

SCHEDULE CFR-3
AGENCY ADMINISTRATION

Page _____

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

AGENCY CODE:_____ **USE WHOLE DOLLARS.**

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	14200	
7	Utilities	14210	
8	Telephone	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 (Attach detail for items costing > $1,000)	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 (Attach detail for items costing > $1,000)	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 (Attach detail for items costing > $1,000)	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	19031	
42	Net Agency Administration (Line 40 minus 41)	19998	

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2004 to December 31, 2004

SCHEDULE CFR-3
AGENCY
ADMINISTRATION

Page _____

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

AGENCY CODE:_____ USE WHOLE DOLLARS.

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	OMRDD Subtotal	19130	
46	SED Subtotal	19140	
47	Shared Programs Subtotal	19150	
48	Other Programs Subtotal**	19160	
49	Total Agency Operating Costs	19170	
	CALCULATION OF RATIO VALUE FACTOR		
50	Net Agency Administration (CFR-3, Line 42)	19999	
51	Total Agency Operating Costs (CFR-3, Line 49)	19171	
52	Ratio Value Factor (Line 50 divided by line 51)	19180	
	ALLOCATION OF AGENCY ADMINISTRATION USING RATIO VALUE ***		
53	OASAS Allocation (line 43 x line 52)	19210	
54	OMH Allocation (line 44 x line 52)	19220	
55	OMRDD Allocation (line 45 x line 52)	19230	
56	SED Allocation (line 46 x line 52)	19240	
57	Shared Programs Allocation (line 47 x line 52)	19250	
58	Other Programs Allocation (line 48 x line 52)	19260	
59	Total Agency Administration (sum lines 53 - 58)	19270	

ADJUSTED RATIO VALUE WORKSHEET (WITHIN STATE AGENCY)

Line No.	State Agency	Cost Codes	Amount
	CALCULATION OF ADJUSTED OPERATING COSTS ******		
60	OASAS Adjusted Subtotal	19310	
61	OMH Adjusted Subtotal	19320	
62	OMRDD Adjusted Subtotal	19330	
63	SED Adjusted Subtotal	19340	
64	Shared Programs Adjusted Subtotal	19350	
	CALCULATION OF ADJUSTED RATIO VALUE FACTOR *******		
65	OASAS Ratio Value Factor (line 53 divided by line 60)	19410	
66	OMH Ratio Value Factor (line 54 divided by line 61)	19420	
67	OMRDD Ratio Value Factor (line 55 divided by line 62)	19430	
68	SED Ratio Value Factor (line 56 divided by line 63)	19440	
69	Shared Programs Ratio Value Factor (line 57 divided by line 64)	19450	

* Totals by State Agency from CFR-1, Line 64. Do not report operating costs for programs 0190, 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 0190, 0880 and 0890 and programs which are exempt from agency administration.
For OMH (line 61) , do not include operating costs for programs 0860, 0870, 1690, 2820, 2860, 4810, 5810, 7810, 8810 and programs with an "A" program code index (startup).
For OMRDD Specific (line 62), do not include operating costs for programs 2091, 3091, 5091 and 7091.
For SED Specific (line 63), do not include operating costs for programs 9800 - 9810.

***** 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.

Please Check State Agency:
- ☐ OMH ☐ SED
- ☐ OMRDD
- ☐ OASAS

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2004 to December 31, 2004

SCHEDULE CFR-4
PERSONAL SERVICES

Page _____

AGENCY NAME:_____

AGENCY CODE:_____

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

REPORT FTE'S TO 3 DECIMAL PLACES.
USE WHOLE DOLLARS.
USE WHOLE HOURS.

Provide all applicable information. Refer to Appendix R for Position Title Codes and Definitions. Check the standard work week or provide the number of hours in the "other" column.

Check the staffing category following the description 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 "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.

Transfer totals to Schedule CFR-1 Line 16 (Program/Site, Program Administration & LGU Administration), or Schedule CFR-3 Line 1 (Agency Administration).

Note: FTE's do not get transferred. Keep program columns consistent throughout the CFR document.

Please Check State Agency:
- ☐ OMH ☐ SED
- ☐ OMRDD
- ☐ OASAS

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

Page _____

AGENCY NAME:_____

AGENCY CODE:_____

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

USE WHOLE DOLLARS.

USE WHOLE HOURS.

Refer to Appendix R for Position Title Codes and definitions. Report only "1099" individuals on this schedule.
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 "Amount Paid" for Positions.											

Transfer totals to Schedule CFR-1 Line 35 (Program/Site).
Note: Keep program columns consistent throughout the CFR document.

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For the Period: January 1, 2004 to December 31, 2004

SCHEDULE CFR-5
TRANSACTIONS WITH RELATED ORGANIZATIONS/INDIVIDUALS

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

SECTION A: ***NOTE: (OASAS and OMRDD providers only): For purposes of this schedule, "related organizations and/or individuals" shall include closely allied entities as described and defined in Article 25.06 of Mental Hygiene Law and on page 18.2 of the CFR Manual. OASAS providers are also directed to refer to Local Services Bulletin 1999-02.***

Question #1: **During the reporting period, were there any PAYMENTS TO related organizations or individuals associated with the provider that involved any OASAS, OMH, OMRDD and/or SED 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 and OMRDD 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, col. 8 above:**

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 and OMRDD 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
						Funding		Funding To/From
Line #	Item #	Name of Related Party/Individual	Street Address	City, State	Type of Financial Support/Aid	To	From	Amount
1						☐	☐	
2						☐	☐	
3						☐	☐	
4						☐	☐	
5						☐	☐	

*** See section 18.0 of the CFR Manual for the relationship key.**

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2004 to December 31, 2004

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", attach detail providing 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 the five highest paid employees whose total annualized salary and contracted payment amount (column 7) is in excess of $50,000 per year

AND

ALL employees whose total annualized salary and contracted payment (column 7) is in excess of $125,000 per year.

	(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.			

5. Number of additional employees and independent contractors whose annualized salary and/or contracted payment amount is in excess of $50,000. _____

* 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)