

**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: