

**NEW YORK STATE
CONSOLIDATED FISCAL REPORT**

For the Period: January 1, 2021 to December 31, 2021

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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
4. submitted financial statements corresponding with the CFR reporting period, or those with an end date within the CFR reporting period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
5. accurately reported all revenue received, including Medicaid and Other Third Parties revenue? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
6. properly disclosed all financial transactions with related organizations/individuals on schedule CFR-5? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
7. accurately calculated agency administration expenses using the ratio value methodology on the CFR, including on schedule DMH-2? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A b) OASAS Service Providers Only: adjusted out all OASAS non-reimbursable expenses from the OASAS State Aid claiming schedules? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
10. remained current with all federal, state, and local employment tax obligations and workers' compensation requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
11. a) OASAS and OPWDD Service Providers: remained current with all rental payments and other occupancy requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A b) OMH Service Providers Only: remained current with all rental payments and other occupancy requirements related to residents in OMH residential programs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
12. OASAS Service Providers Only: complied with all aspects of your property leasing requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
<p>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.</p>		
Name:	Official Title:	Telephone Number:
Signature of Chief Executive Officer:	E-Mail Address:	Date Signed: