NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2013 to June 30, 2014

SCHEDULE OPWDD-1
SCHEDULE OF SERVICES - ICF/DDs Only
Page _____

AGENCY NAME: _____
AGENCY CODE: _____
MEDICAID PROVIDER AGREEMENT NUMBER: _____

SITE ADDRESS: _____
PROGRAM TYPE & CODE NUMBER: _____
OPERATING CERTIFICATE NUMBER: _____

Complete a separate schedule for each site. For each service type or supply, check Cols. 1, 2 or 3. If Col. 2 or 3 is checked, show the dollar amount associated with Col. 2 or 3 in Column 4.

Line No.	SERVICE TYPE	Col. 1 Exclusively Purchased w/ Medicaid Card	Col. 2 Exclusively Purchased by ICF	Col. 3 ICF Purchases Made Only Where MA Card Did Not Cover Items	Col. 4 ICF Purchase Amount Associated w/ Col. 2 or 3
	Pharmacy Services				
1	Prescription Drugs + Insulin				
2	Non-Prescription Drugs				
3	Medical Gloves				
4	Enteral Formulae				
5	Diapers/Underpads				
6	Other Medical Supplies*				
	Equipment				
7	Durable Medical				
8	Prosthetic & Orthotic				
	Service Coordination				
9	Service Coordination				
	Transportation Services				
10	To Medical Office/Clinic				
	Therapy Services (See Definition)				
11	Long Term - Occupational Therapy				
12	Long Term - Physical Therapy				
13	Long Term - Psychologist Services				
14	Long Term - Speech and Language Pathology				
15	Long Term - Dietetics and Nutrition				
16	Long Term - Rehabilitation Counseling				
17	Long Term - Social Work				
18	Long Term - Nursing				
19	Acute Care - Occupational Therapy **				
20	Acute Care - Physical Therapy **				
21	Acute Care - Psychologist Services **				
22	Acute Care - Speech and Language Pathology **				
23	Acute Care - Dietetics and Nutrition **				
24	Acute Care - Nursing **				
25	Other (Detail Required)				

Line No.	SERVICE TYPE	Col. 1 Exclusively Purchased w/ Medicaid Card	Col. 2 Exclusively Purchased by ICF	Col. 3 ICF Purchases Made Only Where MA Card Did Not Cover Items	Col. 4 ICF Purchase Amount Associated w/ Col. 2 or 3
	Aide Services				
26	Home Health Aide				
27	Personal Care Aide				
	Medical Services				
28	General Medical - Direct Service				
29	General Medical - Consultation				
30	Physician - Direct Service				
31	Physician - Consultation				
32	Psychiatrist - Direct Service				
33	Psychiatrist - Consultation				
34	All Dental Services				
35	Clinical Laboratory				
36	X-Ray Diagnostic				
37	Other (Detail Required)				
	Complete this section only if this site is funded for Day Services within the ICF/DD Rate				
38	Day Programming				
39	Day Training				
40	Sheltered Workshop				
41	Education				

Definitions and Notes:

Consultation - Practitioner provides training, oversight and direction to direct care staff.

Direct Service - Practitioner directly treats the consumers.

Nursing - Excludes medical services provided by a nurse practitioner.

***Other Medical Supplies: If Column 2 or 3 is checked, complete Schedule OPWDD-2 for each site as well.**

****Service must be directly related to an acute illness, accident or post-hospitalization health need. If purchased with a Medicaid card, this acute care/rehabilitation service is limited to 3 consecutive months in a calendar year.**

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SCHEDULE OPWDD-2
ICF/DD
MEDICAL SUPPLIES

AGENCY NAME:_____ **PROGRAM TYPE & CODE NUMBER:**_____

AGENCY CODE:_____

MEDICAID PROVIDER AGREEMENT NUMBER:_____ **OPERATING CERTIFICATE:**_____

Complete this schedule if "YES" was checked on line 6 (Other Medical Supplies) in either column 2 or 3 of schedule OPWDD-1.
This schedule should show specifically which items of medical supplies are included or not included in the costs reported on Schedules CFR-1and OPWDD-1 .

Line No.	MEDICAL SUPPLY DESCRIPTION	INCLUDED	NOT INCLUDED	Line No.	MEDICAL SUPPLY DESCRIPTION	INCLUDED	NOT INCLUDED
1	ADHESIVE TAPE			17	GAUZE PADS - STERILE		
2	ADHESIVE BANDAGES			18	GAUZE PADS - NON-STERILE		
3	ADHESIVE PLASTERS			19	IRRIGATION SUPPLIES		
4	ANTISEPTICS			20	OSTOMY CARE PRODUCTS		
5	CANES			21	LAMBS WOOL		
6	CATHETERS			22	SYNTHETIC SHEEP SKIN*		
7	CLOTH/CLOTH-LIKE PRODUCTS			23	LUBRICATING JELLY		
8	COMMODE ACCESSORIES			24	MASTECTOMY PRODUCTS		
9	CONSTIPATION AIDS			25	RESPIRAT./TRACH. CARE PRODUCT		
10	COTTON/COTTON-LIKE PRODUCTS			26	RUBBER FLAT GOODS		
11	CRUTCHES			27	RUBBER MOLDED GOODS		
12	DIABETIC DIAGNOSTICS			28	SUPPORTED GOODS		
13	DIABETIC DAILY CARE			29	SYRINGES		
14	ELECTRIC COOL/HEAT PADS			30	THERMOMETERS		
15	EYE CARE SUPPLIES			31	OTHER (Detail Required)		
16	GAUZE ROLLS						

*** Include all Decubitus supplies here.**

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SCHEDULE OPWDD-3
HUD REVENUES
AND EXPENSES

AGENCY NAME:_____ **PROGRAM TYPE & CODE NUMBER:**_____
AGENCY CODE:_____
MEDICAID PROVIDER AGREEMENT NUMBER:_____ **OPERATING CERTIFICATE:**_____

A. HUD SECTION 8/811 SUBSIDY:*	AMOUNT
(From Commitment Form HUD 92264)	$_____
B. REVENUE:	
1. HUD Section 8/811 Revenues	$_____
2. Other (Detail Required)	$_____
3. Other (Detail Required)	$_____
4. Other (Detail Required)	$_____
5. Other (Detail Required)	$_____
TOTAL REVENUE(Add Lines B1-B5)	$_____
C. REVENUE OFFSETS:	
1. Replacement Reserve Offset (HUD 92264, Line # 21)	$_____
2. Participant Contribution (30% of Adjusted Participant Income)	$_____
3. Other (Detail Required)	$_____
4. Other (Detail Required)	$_____
5. Other (Detail Required)	$_____
TOTAL OFFSETS (Add Lines C1-C5)	$_____

D. EXPENSES INCLUDED ON SCHEDULE CFR-1	LINE # CFR-1	AMOUNT
1. MORTGAGE	_____	$_____
2. REAL ESTATE TAXES	_____	$_____
3. REPAIRS AND MAINTENANCE	_____	$_____
4. MORTGAGE INT. OPERATING EXPENSES	_____	$_____
5. INSURANCE	_____	$_____
6. GROUNDSKEEPING	_____	$_____
7. UTILITIES	_____	$_____
8. OTHER (Detail Required) _____	_____	$_____
9. OTHER (Detail Required) _____	_____	$_____
10. OTHER (Detail Required) _____	_____	$_____
11. OTHER (Detail Required) _____	_____	$_____
12. OTHER (Detail Required) _____	_____	$_____
13. OTHER (Detail Required) _____	_____	$_____
TOTAL EXPENSES (Add Lines D1-D13)		$_____

*HUD Section 8 Subsidy- Estimated project Gross Income based on number of units times Unit Rent per month at 100% occupancy.

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SCHEDULE OPWDD-4
FRINGE BENEFIT EXPENSE AND
PROGRAM ADMINISTRATION EXPENSE DETAIL

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

Line No.	COLUMN NUMBER					
	PROGRAM/SITE ID#					
	PROGRAM TYPE & CODE					
	ITEM DESCRIPTION					
	FRINGE BENEFITS					
1	Social Security					
2	Workers' Compensation					
3	Unemployment Insurance					
4	NYS Disability					
5	Sick Leave Accruals					
6	Health/Dental Insurance					
7	Life Insurance					
8	Pension/Retirement					
9	Other (Detail Required)					
10	Total (Add lines 1 - 9; must equal CFR-1, line 20)					
	PROGRAM ADMINISTRATION (Report the amount included on each specified CFR-1 line that is associated with Program Administration for each site.)					
11	Personal Services (CFR-1, Line 16)					
12	Vacation Leave Accruals (CFR-1, Line 17)					
13	Fringe Benefits (CFR-1, Line 20)					
14	Repairs and Maintenance (CFR-1, Line 22)					
15	Utilities (CFR-1, Line 23)					
16	Staff Travel (CFR-1, Line 25)					
17	Expensed Equipment (CFR-1, Line 28)					
18	Staff Development (CFR-1, Line 34)					
19	Supplies and Materials - non-Household (CFR-1, Line 36)					
20	Telephone (CFR-1, Line 38)					
21	Insurance General (CFR-1, Line 39)					
22	Other OTPS (CFR-1, Line 40) (Detail Required)					
23	Equipment (CFR-1, Line 48)					
24	Property (CFR-1, Line 63)					
25	Adjustments (CFR-1, Line 66) (Detail Required)					
26	Totals (Add lines 11 - 24 minus 25)*					

* This total must equal the portion of CFR-1, line 67, that is directly associated with program administration.