# NEW YORK STATE
**CONSOLIDATED FISCAL REPORT**
***For the Period: July 1, 2007 to June 30, 2008***

**SCHEDULE OMRDD-1**
**SCHEDULE OF SERVICES - ICF/DDs Only**



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

**SITE ADDRESS:** _____
_____
**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 (Specify) | | | | |

| 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 | Specialized (Specify) | | | | |
| | **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 OMRDD-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 OMRDD-2**
**ICF/DD**
**MEDICAL SUPPLIES**



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

**Complete this schedule if "YES" was checked on line 6 (Other Medical Supplies) in either column 2 or 3 of schedule OMRDD-1.**
**This schedule should show specifically which items of medical supplies are included or not included in the costs reported on Schedules CFR-1and OMRDD-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 | | |
| 16 | GAUZE ROLLS | | | | | | |

*** Include all Decubitus supplies here.**

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
*For the Period: July 1, 2007 to June 30, 2008*

**SCHEDULE OMRDD-3**
**HUD REVENUES**
**AND EXPENSES**



**AGENCY NAME:**_____

**AGENCY CODE:**_____

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

| 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 OMRDD-4**

**FRINGE BENEFIT EXPENSE AND**
**PROGRAM ADMINISTRATION EXPENSE DETAIL**



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

| 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) | | | | | |
| 23 | Equipment (CFR-1, Line 48) | | | | | |
| 24 | Property (CFR-1, Line 63) | | | | | |
| 25 | Adjustments (CFR-1, Line 66) | | | | | |
| 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.**