

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2009 to December 31, 2009

SCHEDULE OMRDD-3
HUD REVENUES
AND EXPENSES

Page _____

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

PROGRAM TYPE & CODE NUMBER: _____
 OPERATING CERTIFICATE: _____

	<u>AMOUNT</u>		<u>LINE # CFR-1</u>	<u>AMOUNT</u>
A. <u>HUD SECTION 8/811 SUBSIDY:*</u> (From Commitment Form HUD 92264)	\$ _____	D. <u>EXPENSES INCLUDED ON SCHEDULE CFR-1</u>		
B. <u>REVENUE:</u>		1. MORTGAGE	_____	\$ _____
1. HUD Section 8/811 Revenues	\$ _____	2. REAL ESTATE TAXES	_____	\$ _____
2. Other (Detail Required)	\$ _____	3. REPAIRS AND MAINTENANCE	_____	\$ _____
3. Other (Detail Required)	\$ _____	4. MORTGAGE INT. OPERATING EXPENSES	_____	\$ _____
4. Other (Detail Required)	\$ _____	5. INSURANCE	_____	\$ _____
5. Other (Detail Required)	\$ _____	6. GROUNDSKEEPING	_____	\$ _____
TOTAL REVENUE(Add Lines B1-B5)	\$ _____	7. UTILITIES	_____	\$ _____
		8. OTHER (Detail Required) _____	_____	\$ _____
C. <u>REVENUE OFFSETS:</u>		9. OTHER (Detail Required) _____	_____	\$ _____
1. Replacement Reserve Offset	\$ _____	10. OTHER (Detail Required) _____	_____	\$ _____
(HUD 92264, Line # 21)		11. OTHER (Detail Required) _____	_____	\$ _____
2. Participant Contribution	\$ _____	12. OTHER (Detail Required) _____	_____	\$ _____
(30% of Adjusted Participant Income)		13. OTHER (Detail Required) _____	_____	\$ _____
3. Other (Detail Required)	\$ _____			
4. Other (Detail Required)	\$ _____	TOTAL EXPENSES (Add Lines D1-D13)		\$ _____
5. Other (Detail Required)	\$ _____			
TOTAL OFFSETS (Add Lines C1-C5)	\$ _____			

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