

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
 For the Period: January 1, 2016 to December 31, 2016

SCHEDULE OPWDD-1
 SCHEDULE OF SERVICES -
 ICF/IIDs Only

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	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						Aide Services					
1	Prescription Drugs + Insulin					26	Home Health Aide				
2	Non-Prescription Drugs					27	Personal Care Aide				
3	Medical Gloves					Medical Services					
4	Enteral Formulae					28	General Medical - Direct Service				
5	Diapers/Underpads					29	General Medical - Consultation				
6	Other Medical Supplies*					30	Physician - Direct Service				
Equipment						31	Physician - Consultation				
7	Durable Medical					32	Psychiatrist - Direct Service				
8	Prosthetic & Orthotic					33	Psychiatrist - Consultation				
Service Coordination						34	All Dental Services				
9	Service Coordination					35	Clinical Laboratory				
Transportation Services						36	X-Ray Diagnostic				
10	To Medical Office/Clinic					37	Other (Detail Required)				
Therapy Services (See Definition)						Complete this section only if this site is funded for Day Services within the ICF/IID Rate					
11	Long Term - Occupational Therapy					38	Day Programming				
12	Long Term - Physical Therapy					39	Day Training				
13	Long Term - Psychologist Services					40	Sheltered Workshop				
14	Long Term - Speech and Language Pathology					41	Education				
15	Long Term - Dietetics and Nutrition					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.					
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)										

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2016 to December 31, 2016

SCHEDULE OPWDD-2
ICF/IID
MEDICAL SUPPLIES

Page _____

AGENCY NAME: _____ AGENCY CODE: _____ MEDICAID PROVIDER AGREEMENT NUMBER: _____	PROGRAM TYPE & CODE 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.

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2016 to December 31, 2016

SCHEDULE OPWDD-5
CAPITAL SCHEDULE

Page _____

AGENCY NAME: _____		AGENCY CODE: _____					
		COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5	
		CATEGORY PER DOH PROVIDED SCHEDULE	REIMBURSEMENT PER DOH PROVIDED SCHEDULE	RELATING AMOUNT REPORTED ON CFR-1	CFR-1 LINE NUMBER	DIFFERENCE BETWEEN REIMBURSEMENT AND CFR-1	DETAIL OF COLUMN 4
PROGRAM CODE		LEASE/RENTAL-REAL PROPERTY			49		
PROGRAM TYPE		DEPRECIATION-BUILDINGS/PRINCIPAL			51		
OP CERT #		DEPRECIATION-IMPROVEMENTS/LEASEHOLD IMPROVEMENTS			50/52		
SITE ADDRESS (Line One)		MORTGAGE INTEREST			53		
SITE ADDRESS (Line Two)		SHORT TERM LOAN INTEREST			51		
		OTHER LOAN INTEREST			53		
		START-UP AMORTIZATION			58		
		CO-OP/CONDO FEES			62		
		OTHER (EX. REAL ESTATE TAXES)			56/62		
		DASNY DEBT SERVICE			51/59		
		DASNY OPWDD FEE			60		
		DORMITORY AUTHORITY FEE			60		
PROGRAM CODE		LEASE/RENTAL-REAL PROPERTY			49		
PROGRAM TYPE		DEPRECIATION-BUILDINGS/PRINCIPAL			51		
OP CERT #		DEPRECIATION-IMPROVEMENTS/LEASEHOLD IMPROVEMENTS			50/52		
SITE ADDRESS (Line One)		MORTGAGE INTEREST			53		
SITE ADDRESS (Line Two)		SHORT TERM LOAN INTEREST			51		
		OTHER LOAN INTEREST			53		
		START-UP AMORTIZATION			58		
		CO-OP/CONDO FEES			62		
		OTHER (EX. REAL ESTATE TAXES)			56/62		
		DASNY DEBT SERVICE			51/59		
		DASNY OPWDD FEE			60		
		DORMITORY AUTHORITY FEE			60		

OPWDD-5
Nov. 2016

This schedule must be completed on a site specific basis for each ICF/DD, Day Treatment, Group Day Habilitation and Prevocational Services site.
The corresponding line reported on the CFR-1 does not have to agree with the amount entered in Column 2. See CFR Manual for further instructions.

