

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2010 to December 31, 2010

AGENCY NAME: _____ AGENCY CODE: _____ MEDICAID PROVIDER AGREEMENT NUMBER: _____	SITE ADDRESS: _____ PROGRAM TYPE & CODE NUMBER: _____ OPERATING CERTIFICATE NUMBER: _____
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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	Col. 2	Col. 3	Col. 4	Line No.	SERVICE TYPE	Col. 1	Col. 2	Col. 3	Col. 4
		Exclusively Purchased w/ Medicaid Card	Exclusively Purchased by ICF	ICF Purchases Made Only Where MA Card Did Not Cover Items	ICF Purchase Amount Associated w/ Col. 2 or 3			Exclusively Purchased w/ Medicaid Card	Exclusively Purchased by ICF	ICF Purchases Made Only Where MA Card Did Not Cover Items	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/DD 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)										

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SCHEDULE OPWDD-2
ICF/DD
MEDICAL SUPPLIES

Page _____

AGENCY NAME: _____ AGENCY CODE: _____ MEDICAID PROVIDER AGREEMENT NUMBER: _____	PROGRAM TYPE & CODE NUMBER: _____ OPERATING CERTIFICATE: _____
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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: _____
 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	_____	\$ _____
C. <u>REVENUE OFFSETS:</u>		8. OTHER (Detail Required) _____	_____	\$ _____
1. Replacement Reserve Offset	\$ _____	9. OTHER (Detail Required) _____	_____	\$ _____
(HUD 92264, Line # 21)		10. OTHER (Detail Required) _____	_____	\$ _____
2. Participant Contribution	\$ _____	11. OTHER (Detail Required) _____	_____	\$ _____
(30% of Adjusted Participant Income)		12. OTHER (Detail Required) _____	_____	\$ _____
3. Other (Detail Required)	\$ _____	13. 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.

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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.