# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
*For the Period: January 1, 2004 to December 31, 2004*

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



**AGENCY NAME:** _____ **SITE ADDRESS:** _____

**AGENCY CODE:** _____ _____

**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 | a. Prescription Drugs | | | | |
| 2 | b. Non-Prescription Drugs | | | | |
| 3 | c. Medical Supplies * | | | | |
| 4 | d. Enteral Formulae | | | | |
| 5 | e. Diapers | | | | |
| | **Equipment** | | | | |
| 6 | a. Durable Medical | | | | |
| 7 | b. Prosthetic & Orthotic | | | | |
| | **Service Coordination** | | | | |
| 8 | a. Service Coordination | | | | |
| | **Transportation Services** | | | | |
| 9 | a. To Medical Office/Clinic | | | | |
| | **Therapy Services** (See definition) | | | | |
| 10 | a. Physical Therapy - Direct Service | | | | |
| 11 | b. Physical Therapy - Consultation | | | | |
| 12 | c. Occupational Therapy - Direct Service | | | | |
| 13 | d. Occupational Therapy - Consultation | | | | |
| 14 | e. Speech Therapy - Direct Service | | | | |
| 15 | f. Speech Therapy - Consultation | | | | |
| 16 | g. Psychological - Direct Service | | | | |
| 17 | h. Psychological - Consultation | | | | |
| 18 | i. Physician - Direct Service | | | | |
| 19 | j. Physician - Consultation | | | | |
| 20 | k. Psychiatrist - Direct Service | | | | |
| 21 | l. Psychiatrist - Consultation | | | | |
| 22 | m. 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 |
|---|---|---|---|---|---|
| | **Home Care Services** | | | | |
| 23 | a. Home Health Care | | | | |
| 24 | b. Personal Care | | | | |
| 25 | c. Private Duty Nursing | | | | |
| | **Medical Services** | | | | |
| 26 | a. General Medical - Direct Service | | | | |
| 27 | b. General Medical - Consultation | | | | |
| 28 | c. Nursing | | | | |
| 29 | d. All Dental Services | | | | |
| 30 | e. Clinical Laboratory | | | | |
| 31 | f. X-Ray Diagnostic | | | | |
| 32 | g. Specialized (Specify) | | | | |
| 33 | h. Specialized (Specify) | | | | |
| 34 | i. Specialized (Specify) | | | | |
| | **Complete this section only if this site is funded for Day Services within the ICF/DD Rate** | | | | |
| 35 | a. Day Programming * * | | | | |
| 36 | b. Day Training | | | | |
| 37 | c. Sheltered Workshop | | | | |
| 38 | d. Education | | | | |

**Definitions:**

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

**Direct Service** - Practitioner directly treats the consumers.

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

**** If Line 35 (Day Programming) is completed, attach a list of consumers whose day service costs are included in the ICF/DD rate. Include each consumer's Medicaid Identification number. The list of consumers should only be sent to OMRDD.**

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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:**_____

**If Schedule CFR-1 includes amounts for medical supplies, this schedule must be completed. In addition, medical supplies on Schedule OMRDD-1 should be marked in the column labeled "Included in Report - Yes". This schedule should show specifically which items of medical supplies are included or not included in the costs reported on Schedule CFR-1.**

| Line No. | MEDICAL SUPPLY DESCRIPTION | INCLUDED | NOT INCLUDED | Line No. | MEDICAL SUPPLY DESCRIPTION | INCLUDED | NOT INCLUDED |
|---|---|---|---|---|---|---|---|
| 1 | ADHESIVE TAPE | | | 19 | GLOVES | | |
| 2 | ADHESIVE BANDAGES | | | 20 | IRRIGATION SUPPLIES | | |
| 3 | ADHESIVE PLASTERS | | | 21 | OSTOMY CARE PRODUCTS | | |
| 4 | ANTISEPTICS | | | 22 | LAMBS WOOL | | |
| 5 | CANES | | | 23 | SYNTHETIC SHEEP SKIN* | | |
| 6 | CATHETERS | | | 24 | LUBRICATING JELLY | | |
| 7 | CLOTH/CLOTH-LIKE PRODUCTS | | | 25 | MASTECTOMY PRODUCTS | | |
| 8 | COMMODE ACCESSORIES | | | 26 | RESPIRAT./TRACH. CARE PRODUCT | | |
| 9 | CONSTIPATION AIDS | | | 27 | RUBBER FLAT GOODS | | |
| 10 | COTTON/COTTON-LIKE PRODUCTS | | | 28 | RUBBER MOLDED GOODS | | |
| 11 | CRUTCHES | | | 29 | SUPPORTED GOODS | | |
| 12 | DIABETIC DIAGNOSTICS | | | 30 | SYRINGES | | |
| 13 | DIABETIC DAILY CARE | | | 31 | THERMOMETERS | | |
| 14 | ELECTRIC COOL/HEAT PADS | | | 32 | DISPOSABLE UNDERPADS | | |
| 15 | EYE CARE SUPPLIES | | | 33 | ADULT DISPOSABLE DIAPERS | | |
| 16 | GAUZE ROLLS | | | 34 | TODDLER/OVERNIGHT DISPOS. DIAPERS** | | |
| 17 | GAUZE PADS-STERILE | | | 35 | OTHER (Attach detail for items costing > $1,000) | | |
| 18 | GAUZE PADS-NON-STERILE | | | 36 | OTHER (Attach detail for items costing > $1,000) | | |

*** Include all Decubitus supplies here.**
**** Covered only when medical need may be demonstrated. Diapers will not be covered when incontinence occurs as part of the normal developmental process, i.e. under age three.**

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
***For the Period: January 1, 2004 to December 31, 2004***

**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 (Attach detail for revenue items > $1,000) | $_____ |
| 3. Other (Attach detail for revenue items > $1,000) | $_____ |
| 4. Other (Attach detail for revenue items > $1,000) | $_____ |
| 5. Other (Attach detail for revenue items > $1,000) | $_____ |
| 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 (Attach detail for revenue items > $1,000) | $_____ |
| 4. Other (Attach detail for revenue items > $1,000) | $_____ |
| 5. Other (Attach detail for revenue items > $1,000) | $_____ |
| 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 (Specify) _____ | _____ | $_____ |
| 9. OTHER (Specify) _____ | _____ | $_____ |
| 10. OTHER (Specify) _____ | _____ | $_____ |
| 11. OTHER (Specify) _____ | _____ | $_____ |
| 12. OTHER (Specify) _____ | _____ | $_____ |
| 13. OTHER (Specify) _____ | _____ | $_____ |
| 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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***For the Period: January 1, 2004 to December 31, 2004***

**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 (Attach detail for items costing > $1,000) | | | | | |
| 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.**