

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: January 1, 2005 to December 31, 2005*

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

Page \_\_\_\_\_

<b>AGENCY NAME:</b> _____ <b>AGENCY CODE:</b> _____	<b>SITE ADDRESS:</b> _____ _____ _____ <b>OPERATING CERTIFICATE NUMBER:</b> _____
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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						Home Care Services					
1	a. Prescription Drugs					23	a. Home Health Care				
2	b. Non-Prescription Drugs					24	b. Personal Care				
3	c. Medical Supplies *					25	c. Private Duty Nursing				
4	d. Enteral Formulae					Medical Services					
5	e. Diapers					26	a. General Medical - Direct Service				
Equipment						27	b. General Medical - Consultation				
6	a. Durable Medical					28	c. Nursing				
7	b. Prosthetic & Orthotic					29	d. All Dental Services				
Service Coordination						30	e. Clinical Laboratory				
8	a. Service Coordination					31	f. X-Ray Diagnostic				
Transportation Services						32	g. Specialized (Specify)				
9	a. To Medical Office/Clinic					33	h. Specialized (Specify)				
Therapy Services (See definition)						34	i. Specialized (Specify)				
10	a. Physical Therapy - Direct Service					Complete this section only if this site is funded for Day Services within the ICF/DD Rate					
11	b. Physical Therapy - Consultation					35	a. Day Programming * *				
12	c. Occupational Therapy - Direct Service					36	b. Day Training				
13	d. Occupational Therapy - Consultation					37	c. Sheltered Workshop				
14	e. Speech Therapy - Direct Service					38	d. Education				
15	f. Speech Therapy - Consultation						<b>Definitions:</b>  <b>Consultation</b> - Practitioner provides training, oversight and direction to direct care staff.  <b>Direct Service</b> - Practitioner directly treats the consumers.				
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)										

\* **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**

Page \_\_\_\_\_

<b>AGENCY NAME:</b> _____	<b>OPERATING CERTIFICATE:</b> _____
	<b>MEDICAID PROVIDER AGREEMENT NUMBER:</b> _____
	<b>PROGRAM TYPE &amp; CODE NUMBER:</b> _____
<b>AGENCY CODE:</b> _____	<b>COUNTY CODE:</b> _____

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.

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

Page \_\_\_\_\_

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

<b>A.    <u>HUD SECTION 8/811 SUBSIDY:*</u></b> (From Commitment Form HUD 92264)	<b><u>AMOUNT</u></b> \$ _____	<b>D.    <u>EXPENSES INCLUDED ON SCHEDULE CFR-1</u></b>	<b><u>LINE # CFR-1</u></b>	<b><u>AMOUNT</u></b>
<b>B.    <u>REVENUE:</u></b>				
1. HUD Section 8/811 Revenues	\$ _____	1. MORTGAGE	_____	\$ _____
2. Other (Attach detail for revenue items > \$1,000)	\$ _____	2. REAL ESTATE TAXES	_____	\$ _____
3. Other (Attach detail for revenue items > \$1,000)	\$ _____	3. REPAIRS AND MAINTENANCE	_____	\$ _____
4. Other (Attach detail for revenue items > \$1,000)	\$ _____	4. MORTGAGE INT. OPERATING EXPENSES	_____	\$ _____
5. Other (Attach detail for revenue items > \$1,000)	\$ _____	5. INSURANCE	_____	\$ _____
		6. GROUNDSKEEPING	_____	\$ _____
TOTAL REVENUE(Add Lines B1-B5)	\$ _____	7. UTILITIES	_____	\$ _____
		8. OTHER (Specify) _____	_____	\$ _____
<b>C.    <u>REVENUE OFFSETS:</u></b>		9. OTHER (Specify) _____	_____	\$ _____
1. Replacement Reserve Offset	\$ _____	10. OTHER (Specify) _____	_____	\$ _____
(HUD 92264, Line # 21)		11. OTHER (Specify) _____	_____	\$ _____
2. Participant Contribution	\$ _____	12. OTHER (Specify) _____	_____	\$ _____
(30% of Adjusted Participant Income)		13. OTHER (Specify) _____	_____	\$ _____
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)	\$ _____			
		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**

Page \_\_\_\_\_

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)*					