NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2006 to December 31, 2006

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, complete this schedule if "YES" was checked on line 3 (Medical Supplies) in either column 2 or 3 of schedule OMRDD-1. This schedule should show specifically which items of medical supplies are included or not included in the costs reported on Schedules CFR-1and OMRDD-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		
18	GAUZE PADS-NON-STERILE						

*** 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

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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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.**