

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: July 1, 2019 to June 30, 2020*

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

<b>AGENCY NAME:</b> _____ <b>AGENCY CODE:</b> _____ <b>MEDICAID PROVIDER AGREEMENT NUMBER:</b> _____	<b>SITE ADDRESS:</b> _____ <b>PROGRAM TYPE &amp; CODE NUMBER:</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
<b>Pharmacy Services</b>						<b>Aide Services</b>					
1	Prescription Drugs + Insulin					26	Home Health Aide				
2	Non-Prescription Drugs					27	Personal Care Aide				
3	Medical Gloves					<b>Medical Services</b>					
4	Enteral Formulae					28	General Medical - Direct Service				
5	Diapers/Underpads					29	General Medical - Consultation				
6	Other Medical Supplies*					30	Physician - Direct Service				
<b>Equipment</b>						31	Physician - Consultation				
7	Durable Medical					32	Psychiatrist - Direct Service				
8	Prosthetic & Orthotic					33	Psychiatrist - Consultation				
<b>Service Coordination</b>						34	All Dental Services				
9	Service Coordination					35	Clinical Laboratory				
<b>Transportation Services</b>						36	X-Ray Diagnostic				
10	To Medical Office/Clinic					37	Other (Detail Required)				
<b>Therapy Services (See Definition)</b>						<b>Complete this section only if this site is funded for Day Services within the ICF/IID Rate</b>					
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					<b>Definitions and Notes:</b> <b>Consultation</b> - Practitioner provides training, oversight and direction to direct care staff. <b>Direct Service</b> - Practitioner directly treats the consumers. <b>Nursing</b> - 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/IID**  
**MEDICAL SUPPLIES**

Page \_\_\_\_\_

<b>AGENCY NAME:</b> _____ <b>AGENCY CODE:</b> _____ <b>MEDICAID PROVIDER AGREEMENT NUMBER:</b> _____	<b>PROGRAM TYPE &amp; CODE NUMBER:</b> _____ <b>OPERATING CERTIFICATE:</b> _____
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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-5  
CAPITAL SCHEDULE

Page \_\_\_\_\_

AGENCY NAME: \_\_\_\_\_ AGENCY CODE: \_\_\_\_\_

	CATEGORY PER DOH PROVIDED SCHEDULE	COLUMN 1 REIMBURSEMENT PER DOH PROVIDED SCHEDULE	COLUMN 2 RELATING AMOUNT REPORTED ON CFR-1	COLUMN 3 CFR-1 LINE NUMBER	COLUMN 4 DIFFERENCE BETWEEN REIMBURSEMENT AND CFR-1	COLUMN 5 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		

This schedule must be completed on a site specific basis for each ICF/IID, 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.