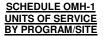
NEW YORK STATE CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2015 to December 31, 2015



Page

AGENCY NAME: AGENCY CODE: COLUMN NUMBER PROGRAM CODE (PROGRAM CODE INDEX) Line No. PROGRAM TYPE PROG/SITE ID. # TYPE OF SERVICE WEIGHT TOTAL WEIGHTED SERVICE VISITS (PROGRAM CODE) FACTOR VISITS HOURS VISITS VISITS HOURS VISITS VISITS HOURS VISITS VISITS HOURS VISITS VISITS HOURS Partial Hospitalization (2200) 1 Regular N/A Collateral N/A 2 Group Collateral N/A 3 N/A Crisis 4 Intensive Psychiatric Rehab. (2320) 5 Regular N/A Clinic Treatment (2100) 6 Service Days 1.00 Continuing Day Treatment (1310) 7 Half Day 0.50 1.00 8 Full Day PROS (6340) (7340) (8340) 9 PROS Units 1.00 Day Treatment (0200) On Site Rehabilitation (0320) 0.33 10 Brief Day 11 Half Day & Pre-Admission Half Day Visits 0.50 12 Full Day & Pre-Admission Full Day Visits 1.00 13 Collateral, Home & Crisis Visits 0.33 Other/Residential/Total 14 All Other 1.00 15 Residential (Patient Days) 1.00 16 Total

Nov. 2015

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Rev.

SCHEDULE OMH-2

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MEDICAID UNITS OF SERVICE BY PROGRAM/SITE

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AGENCY NAME: AGENCY CODE: COLUMN NUMBER PROGRAM CODE (PROGRAM CODE INDEX) Line PROGRAM TYPE No. PROG/SITE ID. # MEDICAID MEDICAID MEDICAID MEDICAID MEDICAID TYPE OF SERVICE WEIGHT TOTAL WEIGHTED SERVICE (PROGRAM CODE) FACTOR VISITS VISITS HOURS VISITS HOURS VISITS HOURS VISITS VISITS HOURS VISITS HOURS VISITS VISITS VISITS Partial Hospitalization (2200) 1 Regular N/A N/A 2 Collateral 3 Group Collateral N/A 4 Crisis N/A Intensive Psychiatric Rehab. (2320) 5 Regular N/A Clinic Treatment (2100) 6 Service Days 1.00 Continuing Day Treatment (1310) 7 Half Day 0.50 8 Full Day 1.00 PROS (6340) (7340) (8340) 9 PROS Units 1.00 Day Treatment (0200) 10 Brief Day 0.33 11 Half Day & Pre-Admission Half Day Visits 0.50 12 Full Day & Pre-Admission Full Day Visits 1.00 0.33 13 Collateral, Home Visit & Crisis Visits Other/Residential/Total 14 All Other 1.00 15 Residential (Patient Days) 1.00 16 Total

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CONSOLIDATED FISCAL REPORT For the Period: January 1, 2015 to December 31, 2015 SCHEDULE OMH-3 CLIENT INFORMATION

Page _____

AGE	NCY NAME:	 										
AGE	NCY CODE:	 										
	COLUMN NUMBER											
Line	PROGRAM CODE (PROGRAM CODE INDEX)	()		())	()		()	()
No.	PROGRAM TYPE											
	PROG/SITE ID. #											
	PERSONS SERVED DURING THE YEAR											
			-					·		·		
1	Persons on Rolls, Beginning of Year											
2	New Persons added to Rolls											
3	Persons Removed from Rolls											
4	Persons on Rolls, End of Year											

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<u>SCHEDULE OMH-4</u> <u>UNITS OF SERVICE</u> <u>BY PAYOR</u> BY PROGRAM/SITE

Page ____

	CY NAME:		
AGENO	CY CODE:		
	1		٦
Line	PROGRAM CODE (PROGRAM CODE INDEX)	()	
No.	PROGRAM TYPE	x y	
	PROG/SITE ID. #		
		TOTAL	REVENUE EARNED
		VISITS	BY PAYOR
	Payors:		1
1	Medicare Only		
2	Medicaid Fee-for-Service Only		
3	Medicaid Managed Care		
4	Medicaid and Medicare		
5	Medicaid Managed Care and Medicare		
6	Medicaid and Other Private Insurance		
7	Medicaid Managed Care and Other Private Insurance		
8	Child Health Plus or Family Health Plus		
9	Other Private Insurance		
10	Participant Fees- Co-pays and Deductibles		
	Uncompensated Care:		
11	Participant Fees- Not Including Co-pays		
12	P Third Party - Not Paid - Non-Covered Services		
13	Third Party - Not Paid - Non-Eligible Licensed Staff		
14	Third Party - Not Paid - Non-Eligible Out of Network		
15	Total Visits (Sum of Lines 1-14)		
16	Visits Eligible for Uncompensated Care Reimbursement (Sum Lines 11-14)		
17	Uncompensated Care Visits (Line 16) as Percent of Total Visits (Line 15)		