# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
*For the Period: January 1, 2015 to December 31, 2015*

**SCHEDULE OMH-1**
**UNITS OF SERVICE**
**BY PROGRAM/SITE**



**AGENCY NAME:**_____
**AGENCY CODE:**_____

| Line No. | COLUMN NUMBER | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | PROGRAM CODE (PROGRAM CODE INDEX) | | ( ) | | | ( ) | | | ( ) | | | ( ) | | | ( ) | | |
| | PROGRAM TYPE | | | | | | | | | | | | | | | | | |
| | PROG/SITE ID. # | | | | | | | | | | | | | | | | | |
| | TYPE OF SERVICE (PROGRAM CODE) | WEIGHT FACTOR | TOTAL VISITS | WEIGHTED VISITS | SERVICE HOURS | TOTAL VISITS | WEIGHTED VISITS | SERVICE HOURS | TOTAL VISITS | WEIGHTED VISITS | SERVICE HOURS | TOTAL VISITS | WEIGHTED VISITS | SERVICE HOURS | TOTAL VISITS | WEIGHTED VISITS | SERVICE HOURS |
| | Partial Hospitalization (2200) | | | | | | | | | | | | | | | | |
| 1 | Regular | N/A | | | | | | | | | | | | | | | |
| 2 | Collateral | N/A | | | | | | | | | | | | | | | |
| 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) | | | | | | | | | | | | | | | | |
| | On Site Rehabilitation (0320) | | | | | | | | | | | | | | | | |
| 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 | | | | | | | | | | | | | | | |
| 13 | Collateral, Home & Crisis Visits | 0.33 | | | | | | | | | | | | | | | |
| | Other/Residential/Total | | | | | | | | | | | | | | | | |
| 14 | All Other | 1.00 | | | | | | | | | | | | | | | |
| 15 | Residential (Patient Days) | 1.00 | | | | | | | | | | | | | | | |
| 16 | Total | | | | | | | | | | | | | | | | |

# NEW YORK STATE
## CONSOLIDATED FISCAL REPORT
*For the Period: January 1, 2015 to December 31, 2015*

**SCHEDULE OMH-2**

**MEDICAID**
**UNITS OF SERVICE**
**BY PROGRAM/SITE**



**AGENCY NAME:**_____
**AGENCY CODE:**_____

| Line No. | COLUMN NUMBER | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | PROGRAM CODE (PROGRAM CODE INDEX) | | ( ) | | | ( ) | | | ( ) | | | ( ) | | | ( ) | | |
| | PROGRAM TYPE | | | | | | | | | | | | | | | | | |
| | PROG/SITE ID. # | | | | | | | | | | | | | | | | | |
| | | | MEDICAID | | | MEDICAID | | | MEDICAID | | | MEDICAID | | | MEDICAID | | |
| | TYPE OF SERVICE (PROGRAM CODE) | WEIGHT FACTOR | TOTAL VISITS | WEIGHTED VISITS | SERVICE HOURS | TOTAL VISITS | WEIGHTED VISITS | SERVICE HOURS | TOTAL VISITS | WEIGHTED VISITS | SERVICE HOURS | TOTAL VISITS | WEIGHTED VISITS | SERVICE HOURS | TOTAL VISITS | WEIGHTED VISITS | SERVICE HOURS |
| | Partial Hospitalization (2200) | | | | | | | | | | | | | | | | |
| 1 | Regular | N/A | | | | | | | | | | | | | | | |
| 2 | Collateral | N/A | | | | | | | | | | | | | | | |
| 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 | | | | | | | | | | | | | | | |
| 13 | Collateral, Home Visit & Crisis Visits | 0.33 | | | | | | | | | | | | | | | |
| | Other/Residential/Total | | | | | | | | | | | | | | | | |
| 14 | All Other | 1.00 | | | | | | | | | | | | | | | |
| 15 | Residential (Patient Days) | 1.00 | | | | | | | | | | | | | | | |
| 16 | Total | | | | | | | | | | | | | | | | |

# NEW YORK STATE
CONSOLIDATED FISCAL REPORT
*For the Period: January 1, 2015 to December 31, 2015*

**SCHEDULE OMH-3**
**CLIENT**
**INFORMATION**



**AGENCY NAME:**_____
**AGENCY CODE:**_____

| Line No. | | | | | | |
|---|---|---|---|---|---|---|
| | COLUMN NUMBER | | | | | |
| | PROGRAM CODE (PROGRAM CODE INDEX) | ( ) | ( ) | ( ) | ( ) | ( ) |
| | 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 | | | | | |

**NEW YORK STATE**
**CONSOLIDATED FISCAL REPORT**
***For the Period: January 1, 2015 to December 31, 2015***

**SCHEDULE OMH-4**
**UNITS OF SERVICE**
**BY PAYOR**
**BY PROGRAM/SITE**
**Page _____**

**AGENCY NAME:**_____
**AGENCY CODE:**_____

| Line No. | | | |
|---|---|---|---|
| | | | |
| | **PROGRAM CODE (PROGRAM CODE INDEX)** | ( ) | |
| | **PROGRAM TYPE** | | |
| | **PROG/SITE ID. #** | | |
| | | **TOTAL VISITS** | **REVENUE EARNED BY PAYOR** |
| | **Payors:** | | |
| 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 | **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)** | | |