

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
*For the Period: January 1, 2013 to December 31, 2013*

**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	
<b>Partial Hospitalization (2200)</b>																		
1	Regular	N/A																
2	Collateral	N/A																
3	Group Collateral	N/A																
4	Crisis	N/A																
<b>Intensive Psychiatric Rehab. (2320)</b>																		
5	Regular	N/A																
<b>Clinic Treatment (2100)</b>																		
6	Service Days	1.00																
<b>Continuing Day Treatment (1310)</b>																		
7	Half Day	0.50																
8	Full Day	1.00																
<b>PROS (6340) (7340) (8340)</b>																		
9	PROS Units	1.00																
<b>Day Treatment (0200)</b>																		
<b>Sheltered Workshop (0340)</b>																		
<b>On Site Rehabilitation (0320)</b>																		
10	Brief Day	0.33																
11	Half Day	0.50																
12	Full Day	1.00																
13	Collateral	0.33																
14	All Other	1.00																
15	Residential (Patient Days)	1.00																
16	<b>Total</b>																	

**NEW YORK STATE  
CONSOLIDATED FISCAL REPORT**

*For the Period: January 1, 2013 to December 31, 2013*

**SCHEDULE OMH-2**

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

Page \_\_\_\_\_

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
	<b>Partial Hospitalization (2200)</b>																
1	Regular	N/A															
2	Collateral	N/A															
3	Group Collateral	N/A															
4	Crisis	N/A															
	<b>Intensive Psychiatric Rehab. (2320)</b>																
5	Regular	N/A															
	<b>Clinic Treatment (2100)</b>																
6	Service Days	1.00															
	<b>Continuing Day Treatment (1310)</b>																
7	Half Day	0.50															
8	Full Day	1.00															
	<b>PROS (6340) (7340) (8340)</b>																
9	PROS Units	1.00															
	<b>Day Treatment (0200)</b>																
10	Brief Day	0.33															
11	Half Day	0.50															
12	Full Day	1.00															
13	Collateral	0.33															
14	All Other	1.00															
15	Residential (Patient Days)	1.00															
16	Total																

**NEW YORK STATE**  
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*For the Period: January 1, 2013 to December 31, 2013*

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

Page \_\_\_\_\_

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, 2013 to December 31, 2013*

**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
<b>Payors:</b>						
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					
<b>Uncompensated Care:</b>						
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	<b>Total Visits (Sum of Lines 1-14)</b>					
16	<b>Visits Eligible for Uncompensated Care Reimbursement (Sum Lines 11-14)</b>					
17	<b>Uncompensated Care Visits (Line 16) as Percent of Total Visits (Line 15)</b>					